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COMMISSION OF INQUIRY
INTO THE
NON-MEDICAL USE OF DRUGS

COMMISSION D'ENQUETE
SUR L'USAGE DES DROGUES
A DES FINS NON MEDICALES

May 15, 1970
Board of Education Building
HAMILTON, Ontario

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2 INTO THE
3 NON-MEDICAL USE OF DRUGS
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6 SUR L'USAGE DES DROGUES
7 A DES FINS NON MEDICALES

8 BEFORE:

9 Gerald LeDain, Chairman,
10 Ian Campbell, Member,
11 H. E. Lehmann, M.D., Member,
12 James J. Moore, Executive Secretary,
13 J. Peter Stein, Member.

14 RESEARCH:

15 Dr. Charles Farmilo.

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17
18
19 SECRETARY TO THE CHAIRMAN:

20 Vivian Luscombe.

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23 May 15, 1970
24 Board of Education Building
25 HAMILTON, Ontario
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Hamilton, Ontario
May 15, 1970

--- Upon commencing at 9:40 A.M.

THE CHAIRMAN: Good morning, ladies and gentlemen. I call this hearing of the Commission of Inquiry into the Non-Medical Use of Drugs to order.

Could you come closer down to the front? Do you mind doing that? I think it will facilitate our discussions.

Thank you very much.

I will just make a brief introduction this morning. I made a longer statement yesterday. I would just like to introduce the members of the Commission who are present and our staff, and to say a few words about our terms of reference. On my far right is ^{Dean} Ian Campbell from Montreal; on my immediate right is Dr. Heinz Lehmann of Montreal; I am Gerald Le Dain; on my left is Mr. James Moore, Executive Secretary of the Commission; on Mr. Moore's left is Mr. Peter Stein, Commissioner from Vancouver; and at the table is Dr. Charles Farmilo, Research Associate of the Commission and Mrs. Vivian Luscombe, my Secretary on the Commission. We regret very much that our colleague on the Commission, Professor Marie Andree Bertrand of Montreal, is unable to be at this Hearing because of illness.

I think probably everyone here present is sufficiently familiar with the background of our appointment, our terms of reference, but perhaps a brief reminder will be helpful. We were

1 appointed at the end of May last year as an independent
2 Commission under the Inquiries Act by the Federal
3 Government and upon the recommendation of the Minister
4 of Health and Welfare and we are asked to inquire into
5 three things, the effects of psychotropic drugs and
6 substances, on the / individual with the current state of medical
7 knowledge as to these effects; secondly, the extent and
8 the patterns of use of these drugs. Thirdly, the
9 motivation underlying such use and also what you might
10 call the social context of such use, the related social,
11 economic, educational, philosophical factors; what is
12 the meaning of it for our time? And finally, on the
13 basis of our findings, to make recommendations to the
14 Federal Government as to what it can do, alone or with
15 other levels of Government, Provincial, Municipal,
16 to-- the terms of reference say "reduce the
17 dimensions of the problem involved in such use." Now
18 I should stress that we are looking at all of the
19 psychotropic or mood modifying drugs and substances,
20 not just one or two of them, and we have divided them
21 into roughly eight categories, but certainly the most
22 important ones, I think, that we are looking at are
23 the hallucinogenics, cannabis, LSD, mescaline, as
24 examples. We are looking at the amphetamines, the
25 barbiturates and minor tranquilizers, volatile solvents,
26 glue sniffing, and of course the opiate-narcotics of
27 which heroin is an example and also alcohol.

28 So that we have to look
29 at this whole spectrum and we are, in effect, trying to
30 determine what is a sound social policy with respect to

1 this phenomenon, a sound social response and the law
2 of course is one element of this response, one instrument
3 of social control, but only one in this whole picture.
4 And we are looking at, obviously, education, information
5 and treatment and other aspects of the social response.
6 So it is a very comprehensive inquiry and I think we
7 have said to ourselves at times there is almost nothing
8 about the human condition to-day that is not relevant
9 to this question. Now I would just like to say a word
10 for the benefit of those who weren't here yesterday
11 about our procedure at these Hearings. We have always
12 a certain number of scheduled briefs as we have to-day
13 but at the conclusion of a scheduled submission--we
14 ask those making such a submission to be seated at
15 the table here--there is an opportunity for questions
16 or comments from the Commission and from everyone now
17 present, and we have tried to have a true public forum
18 at our Inquiries, and it is for
19 that reason we have followed a fairly informal procedure
20 and it is not necessary to have a formal submission,
21 and I hope you will all feel free to give us the
22 benefit of your views. We have placed microphones in
23 the aisles here, if you would be good enough to use
24 the microphone as we are recording here and it is
25 difficult if it can't be heard clearly.

26 And so I will call now
27 upon the first submission, the Hamilton Academy of
28 Medicine, represented by Dr. Gordon Cameron, President
29 of the Academy, and I understand that Dr. Cameron is
30 accompanied by Dr. Anderson, Chairman of the Committee

1 on Drugs of the Academy. At least Dr. Anderson has
2 participated, I gather, in the preparation of this
3 submission.

4 DR. CAMERON: Mr. Chairman,
5 Members of the Commission, I am Dr. Cameron, the
6 President of the Academy. The Academy as an institution
7 represents about 650 physicians.

8 THE CHAIRMAN: Are you
9 comfortable there? I don't want you to have to
10 stretch like that to see us.

11 DR. CAMERON: I'm not
12 going to say very much and it's just by way of
13 introducing Dr. Anderson. Certainly as an institution
14 we have a concern about this problem, as citizens are
15 concerned about the social aspect. Some of our members
16 are more experiences than others and I am identifying
17 Dr. Anderson as one having particular contact with
18 this problem, and^{he}/will present the brief.

19 THE CHAIRMAN: Thank you.
20 Dr. Anderson?

21 DR. ANDERSON: Perhaps I
22 will begin by pointing out that I think this brief
23 is unique, in that it was not written by a Committee
24 but was written virtually by the Membership of the
25 Academy, who were all invited to participate in its
26 composition of the report. They were invited to submit
27 written remarks and they filled out a relatively
28 elaborate questionnaire which recorded each physician's
29 experience and opinions concerning the drug scene at
30

1 the moment. We had a very short period of time indeed
2 to prepare this and of the 650 members polled the
3 report which we submitted contains the responses of
4 the first 268 to be received as of yesterday.

5 THE CHAIRMAN: Excuse me.
6 I wonder, Dr. Anderson, could you tell us what the
7 Academy is exactly, and its relationship to the other
8 bodies in the Profession? What exactly is it?

9 DR. CAMERON: Perhaps I
10 could comment on that, sir. The Academy of Medicine
11 is a Professional Organization, a volunteer-organiza-
12 tion of physicians practising in the Hamilton area.
13 It has existed in one form or another since Hamilton
14 began but its formal incorporation was in the early
15 '30's. It has presently, voluntarily among its member-
16 ship, about 98% of the physicians practising in the
17 area. This number indicated of 650 includes some
18 non-resident members who are practising in surrounding
19 neighbourhoods as well.

20 THE CHAIRMAN: Is there
21 any other local medical association?

22 DR. CAMERON: No, this is
23 an all-encompassing association.

24 THE CHAIRMAN: All-
25 encompassing. Thank you.

26 DR. ANDERSON: There are a
27 number of, I think, particularly interesting things
28 about the report. Point number one would be that
29 when you look at a population such as the population
30 of physicians that we are sampling, they have, I

1 suppose, had roughly equal educational backgrounds,
2 they have equal access to the published literature on
3 the subject, they work in the same geographical region
4 and they all have access to clinical material, and we
5 found it interesting that they vary widely in their
6 opinions on the relative dangers of various drugs,
7 their attitudes toward the drug user, their explanation
8 of causative mechanisms for problems, their types of
9 the solutions to problems and their attitudes towards
10 the legal management of the non-medical use of drugs.
11 They, as well as physicians, of course, are also citizens
12 and in this particular area I think it is very
13 difficult for professionals to sort out the difference
14 between their professional lives and the scientific
15 laws they have and their own attitudes as citizens and
16 parents.

17 This report tried to show
18 the wide range of attitudes and opinions that we
19 found within the profession and without any hopes
20 of trying to reconcile all the views expressed within
21 the framework. It would have been, I think, probably
22 immoral to warp the evidence as shown by the member-
23 ship who were asked in good faith to submit their
24 personal opinions in this and so we have tried to show
25 the spectrum rather than to try to boil it together
26 and come up with something that really did represent
27 the opinions of any one.

28 I will just go through a
29 few of the areas that I think might be of interest.
30 The first of these is the degree of involvement that

1 the physicians in this community have with drug problems,
2 and of someone who lives in the area like myself, I
3 was surprised at the volume of cases seen by physicians.
4 On the basis of the data drawn from this sample which
5 represents slightly less than 50% of the physicians,
6 three things are listed in the report. Physicians
7 handling bad trips on the hallucinogenic drugs came to
8 740 per year. This is the Hamilton area, Dundas,
9 Ancaster, Burlington. And if you projected that, if
10 you just simply mathematically multiplied it by 2.2
11 to give the supposed number handled by all physicians
12 it would come out to 1,630. I think there is a very
13 good possibility that that figure would be too high
14 and that those physicians who in fact are dealing with
15 drug users would respond early in the questionnaire,
16 but I think we could be relatively safe that this figure
17 of 740 would be a minimum number of cases. Amphetamine
18 abusers, 228 per year seen by physicians and this would
19 be almost certainly a very small percentage as I say,
20 and Hepatitis secondary to intervenous injection of
21 drugs, 60 per year as reported by this group.

22 The second area on Page 3
23 of the report that the respondents were asked to rate
24 eight substances with respect to their effects on
25 health, and a grade was provided for them using a 7 point
26 scale on which the score of one represents it extremely
27 dangerous and a score of seven, harmless. And the
28 report shows in tabular form the responses. Now, I
29 will read out the list of substances and the mean
30 score, again remembering that one is extremely dangerous

1 and seven is harmless.

2 And I will read from the
3 harmless end towards the --- that is I will read from
4 the dangerous end to the harmless end. Heroin received
5 the score of 1.3. Next on the list LSD at 1.6;
6 amphetamines 2.0; the volatile solvents, 2.1;
7 barbiturates, which is misspelled in the report, 3.1;
8 cigarettes, 3.3; alcohol, 3.7; and marijuana 4.0.

9 We did statistical tests
10 on this and derivations of figures on this gives the
11 range of responses of the individuals that made up
12 the sample that produced the mean score, so the
13 deviation---the higher the number is, the more
14 heterogeneous the feelings were of the people
15 studied, and it is of some interest that the least
16 variation in opinion was in the area of heroin,
17 0.7; and the most variation was at the other end
18 of the scale for marijuana at 1.7.

19 So the least dangerous of
20 the drugs shown on the Table in their opinion was
21 marijuana and that includes cigarettes and alcohol.
22 And you will note the most variability in expanses
23 was at the end of the scale also. Among the questions
24 that were asked was "which of the following do you
25 think constitutes the greatest risk to the future of
26 the person who uses marijuana?" And three responses
27 were possible; health effects, the effects of breaking
28 the law--that is the legal implication, or both about
29 the same. And only 25% stated that they thought that
30 health effects were the major hazard of marijuana.

1 44% said the major hazard was the legal effects upon
2 the individual, 32% said both about the same. So that
3 76% of the respondents thought that breaking the law
4 was the most serious hazard or ranked as serious as
5 the effects of marijuana on the person.

6 Here again, the difference
7 is in the almost strict personality that we are sure of
8 in this area; when asked if the purchase of marijuana
9 should become legal, 73% said no. Of the 27% that
10 answered yes, there were age stipulations; 5% said
11 there should be no age restriction, 8% said over the
12 age of 18, and 11% said over the age of 21.

13 Here again there is no
14 consensus to the report/^{as} to the range of responses.
15 Two different physicians made the following two
16 statements: "Please transmit a very definite plea that
17 marijuana and other drugs not be legalized in any way
18 and laws enforced strongly." Another physician said:
19 "Marijuana and hashish have been used in the Middle
20 and Far East for many, many years with no more ill
21 effects than alcohol - why not legalize it?" Among
22 those deciding against the legalization of marijuana
23 however, the majority opinion was towards modification
24 of law enforcement as presently applied against drug
25 users. This was expressed in such statements as
26 "Legislation will do nothing to improve the situation";
27 and "Take drugs abuse out of the area of law enforce-
28 ment and place it in the context of Public Health."

29 Another area which we wish
30 to draw to your attention from ourselves concerned the

1 medical and non-medical use of drugs and how the two
2 blend together, and the health related professions'
3 need to re-examine their contributions to the drug
4 oriented society of which youthful drug abuse forms but
5 a small part. The wide spread use by adults of
6 tranquillizers, sleeping tablets and amphetamines all
7 provided on prescription has formed a model which
8 has been copied by our young people.

9 Strong opinions were expressed
10 by respondents that "the abuse of amphetamines and
11 barbiturates by middle-aged housewives is a more
12 important problem than the drug habits of their
13 teenage children" and "We should abolish the sale
14 and manufacture of amphetamines completely."

15 We recognize youthful drug
16 abuse as a symptom of underlying problems in the
17 person and in society and realize that therapy aimed
18 at the drug itself will fail. However, it is common
19 to place disturbed adults on long term drug therapy
20 aimed at symptomatic relief and ignore the causative
21 factors. The Society in this profession recommend to
22 young people that they change their life style as
23 alternatives to drug abuse. We should consider the
24 same possibility in assisting adult patients to cope
25 with their anxieties and difficulties. In the words
26 of one physician "Adults should realize themselves
27 that drugs can't solve their mental problems. They
28 will have to give the example to their children."

29 In the prevention and
30 treatment, the overwhelming recommendation for

1 measures to assist in the prevention of drug abuse was
2 for improved educational programmes aimed at young
3 people, their parents, and a very important thing,
4 aimed at themselves - at the physicians.

5 One physician stated that
6 the most needed factor in the prevention of drug
7 problems is good parents. Another referred to our
8 lack of alternatives to drugs as a method of coping
9 with widespread social illness and unrest. Another
10 stated that "drug abuse is merely a symptom of the
11 present state of our society yet many doctors believe
12 you can cure it without treating the underlying disease.
13 If you have an acute appendix, you treat the appendix
14 not the blood count."

15 One respondent states:
16 "What little I see has indicated a 'sick' family, not
17 a sick teenager. I suggest we need more family
18 treatment centres."

19 Only five physicians
20 identified stricter law enforcement and more severe
21 punishment for offenders as the major methods to
22 solve drug problems.

23 Respondents - and I think
24 that this has some interest apart from any value that
25 this report might have in the deliberations of this
26 Commission, the visit of the Commission
27 and the preparation of the report and the questioning
28 of local physicians has stimulated a number of reviews
29 to begin within the community, an assessment of how
30

purely, in general, we are handling things, an assessment of the kind of facilities we have that could be used in this area that haven't been, the lack of communication between some who are interested in this area and others who are not. In this area, particularly, we have been looking over the past particularly as to how facilities can be mobilized in this area.

The overwhelming^{response}/showed a need for a centre with skilled staff entirely devoted to the treatment and rehabilitation of young people with drug problems. A number of respondents reported that drug users shun existing facilities because they fear being reported to the police and because they anticipate unsympathetic treatment.

The report shows five areas where the medical profession and other concerned people may be useful in treatment^{of} people with problems with drugs. Briefly, one area is people with acute problems such as bad trips and overdoses; secondly, those with medical complications such as hepatitis following contamination from needles; thirdly, hospital detoxification of people who are chronic users, especially of this particular type who are chronic amphetamine users; fourthly, the problem of dealing with a young person whose major problem is that he has been arrested in the general category of drug abuse. And the report points out that while many thousands of people are using the legal drugs privately and cautiously with no apparent harmful effects, a very small percentage of this population becomes

1 identified as overt drug users and come to our
2 attention because of breakdowns in living, medical
3 complications, severe drug reactions and, most
4 particularly, arrest. It is this segment of the drug
5 subculture that is being prosecuted by our society.
6 If use of these drugs is illegal, there are so many
7 more times the number of those arrested who are using
8 it, who are doing it innocuously. The healthy
9 lawbreakers are spared, but the ill are punished by
10 our society. All such drug users reaching our courts
11 should receive careful presentence evaluation so the
12 offender can be recognized and sentencing then done
13 from the standpoint of rehabilitation rather than
14 punishment. Evaluation could best be done by a
15 specialized team, pre-trial and is probably one of
16 the minor things our society is doing right now.

17 At this point is the
18 problem of assisting young people using drugs once
19 they have been identified and finding a way for them
20 to develop a future for themselves in this
21 (portion inaudible) of rehabilitation services.
22 Although we may use many high-powered phrases about
23 rehabilitation and talk about the many instances we
24 have had, while
25 it is difficult to find an unskilled job for a young
26 drug offender who has perhaps long hair, we'll see
27 how unready our communities are to assist in this
28 problem.

29 The next general area is the
30 education of physicians, and we find it particularly

1 significant that this population of physicians over-
2 whelmingly asked for assistance in learning about the
3 medical management of this and learning how they
4 might be of assistance in treating it, and they have
5 provided very elaborate requests for the kinds of
6 information they want and the methods that they want
7 to have it presented. I might perhaps just close by
8 reading the six summary recommendations arising from
9 much larger data.

10 Number one, courses should
11 be organized at once for the continuing education of
12 physicians in the area of drug problems and medical
13 schools should ensure it is included in the under-
14 graduate curriculum.

15 Two, physicians should give
16 careful consideration to the implication of the long-
17 term use of prescription drugs such as tranquillizers,
18 sleeping tablets, and amphetamines.

19 Three, we must listen
20 seriously to the voice of alienated young people and
21 examine the quality of our lives as individuals, families,
22 and communities. Rather than deny or ignore the
23 problems we find we must begin at once to put our
24 houses in order.

25 Four, communities should
26 evaluate the facilities available for the treatment
27 and rehabilitation of the young people with drug problems.
28 Where feasible, a central facility should be established
29 to deal with all aspects of the problem, to coordinate
30 the various community services and to conduct research

patterns
into of drug use, drug effects, and to evaluate
treatment programmes.

Five, drug offenders
reaching the courts should be evaluated individually
and placed into a programme whose goal is rehabilitation
rather than punishment.

Six, education programmes
designed for young people and their parents should be
"people-orientated" rather than "drug-orientated".
Rather than emphasizing the danger of drug use, the
problems of living and how they are coped with should
be the theme. People of all ages should be made
aware of the crutches, escapes, and mood modifiers
that we all use, consciously or not. Changes in
attitudes rather than the acquisition of factual,
pharmacological knowledge should be the aim of such
programmes.

That's the end of our
submission, Mr. Chairman.

THE CHAIRMAN: Thank you
very much, Dr. Cameron, and Dr. Anderson.

Dr. Anderson, I think we
would be very interested to hear in greater detail
what you think is the best organization of treatment
facilities for the various objectives or needs that
you outline here, and this is a problem that we are
trying to get our mind around. We have heard various
recommendations, and I might say among the things we
have heard for example, is that the general hospitals
as presently constituted don't seem able to cope,

1 either because of their facilities or possibly because
2 of training personnel, don't seem able to cope with
3 some of the emergency problems of Speed, the use of
4 Speed for example. And we have heard about the
5 inadequacy of psychiatrists, the lack of adequate
6 psychiatric services which are readily available, in the
7 general hospital facility. And great emphasis has been
8 placed on the skill of young people in talking them
9 down and handling Speed, Speed freak experiences.
10 And then we have heard it said that we shouldn't be
11 dissipating our resources in a lot of specialized
12 centres, but that we should organize all our community
13 services, social services, psychological services in
14 this field in a centre which is capable of dealing
15 in a comprehensive way with drug dependency problems
16 of all kinds. We are frank to say that we are trying
17 to think our way through this problem, it is one of
18 the most important questions and we have had all these
19 impressions, and we are trying to see what kind of ---
20 what is the most effective system of treatment that we
21 can organize and apply our resources as efficiently as
22 possible.

23 Can you help us on that?

24 DR. ANDERSON: Certainly I
25 don't think anyone has the answer to the problem,
26 because it isn't one problem, there are a whole
27 complex of things involved. When you look at how a
28 community deals even medically in the broader sense
29 with the young people in difficulties with drugs, there
30 are two areas; one is the area of facilities,

1 in other words, intravenous set-ups, beds and so on,
2 the hardware and the technical help, but even more
3 importantly the attitudes of the people who deal with
4 the young people, so that within a community almost
5 certainly all communities have the technical gadgetry
6 to help anyone with a medical problem arising from the
7 use of drugs. Very few communities have the personnel
8 who will apply it with the same kind of compassion
9 and attitudes that they would for people in other
10 kinds of difficulties. So I think it is a tough thing
11 for us to realize a very strong bias and the very
12 rather warped attitudinal approaches that we have
13 ourselves in dealing with these people, and so they
14 are widely alienated almost from the moment they
15 enter the doors of our institutions in the approach
16 of the people who see them first, in the feelings
17 that are projected to them of the person.

18 Secondly, I suppose that
19 we talk about the drug problem as though someone who
20 has been blowing a little grass for the weekend and
21 someone who is hung up on Speed are all in the same
22 category, as though there aren't as many problems
23 as there are people in the drug area as there are in
24 any other area, and so some kid who has a bad trip
25 and is scared out of his wits and comes into the
26 emergency then and wakes up and finds himself committed
27 to a psychiatric hospital as some sort of a wierd,
28 sick, psychiatric person is an atrocity story that
29 is heard in the drug subculture very soon, and you are
30 scared to go in even for minimal medical help for fear

1 you are going to be categorized as something much worse
2 than you are and that you may no longer have control
3 of what happens to you next. So when we plan treatment,
4 we shouldn't be grandiose and try to design the whole
5 life of the person. Our first step should really
6 be to deal with the problem as we see fit. If
7 he has hepatitis, we should treat him efficiently and
8 compassionately for the disease that brought him in
9 and contract for further things later on.

10 MR. CAMPBELL: Dr. Anderson,
11 the concern that has frequently been expressed by
12 drug users, that if they visit a hospital or when you
13 visit a physician they are very apt to be reported to
14 the police as drug users. Has your Academy taken any
15 clear position on this matter of, I suppose, it's
16 medical ethics?

17 DR. CAMERON: Well, as an
18 institution this has not been discussed, and there has
19 been no clear indication of the general feeling of
20 the Members. I would think it is unlikely that the
21 average physician accepts a legal compulsion to report
22 such knowledge to the police except in extreme cases.

23 MR. CAMPBELL: What about the
24 hospitals? Have you any idea of the hospitals?

25 DR. CAMERON: I can't speak
26 officially, but again I don't believe there is a rigid
27 mechanism in this direction. There are certain settled
28 pressures that we have become aware of in that in
29 order to acquire medical information as to the medical
30 nature of unknown drugs being taken, the climate has

1 changed so that this information, I gather, is only
2 available through legal channels which paradoxically
3 has made the medical care of some unfortunate people
4 more difficult.

5 DR. LEHMANN: Well, Dr.
6 Cameron, I can't quite see the connection. If an
7 analysis of a sample, street sample which produced
8 the toxic reaction, is required, let's suppose it would
9 be, do you mean that the police would not accept to
10 make an analysis and furnish the results unless they
11 were also given the name of the person who brought
12 it in, because that seems to be quite unrelated?

13 DR. CAMERON: This is my
14 impression and I would ask Dr. Anderson --- I would
15 pass that to him because he would have more factual
16 knowledge on it.

17 DR. LEHMANN: Also in
18 connection with what you just said, you said that
19 few physicians would accept legal compulsion. Well,
20 if this is so, did you imply that some physicians then
21 might reserve their liberty for themselves regardless
22 of what the law says or anything else says, to report
23 to the police if they feel this should be done, or
24 would they feel themselves constrained by medical
25 ethics?

26 DR. CAMERON: I would stress
27 that this is tending to go into an area of speculation
28 therefore I can't claim authoritative information that
29 I present. I would say that there are some clear
30 indications for a physician to take --- to respond to

1 a legal obligation with regard to areas introduced
2 in the treatment of these patients. I would say
3 that on the other extreme, the general feeling of the
4 physician is that the interests of the patient is his
5 prime consideration and that there is a grey area in
6 between which rests often with the judgment of the
7 physician and the amount of responsibility he is
8 willing to take in the matter. I can't define it
9 more clearly than that.

10 DR. LEHMANN: I see this.

11 And if we as Commissioners are constantly labouring
12 this point it is for the following reason; generally
13 and practically without exception in every city we
14 have been to, the claim from the kids in the community
15 is that they are afraid to go to hospitals for a
16 variety of reasons; one you just pointed out, Dr.
17 Anderson, namely the sometimes subtle or not so subtle
18 hostility projected towards them. And obviously as
19 you pointed out, this should be changed. But that
20 isn't so easy. It means changing personal attitudes
21 in people, and doctors might work at it and hospital
22 personnel. The other objection is that there is
23 always fear. That is without exception brought out
24 that if we go to a hospital, we will be reported to the
25 police. So there is a very explicit reason given why
26 they fear hospital treatment and why they often suffer
27 perhaps considerable danger. Sometimes we have been
28 told they would rather die than to the hospital.
29 Now this seems to be an area where some clear cut,
30 black and white attitudes

1 can very quickly be produced practically overnight, and
2 I am just wondering why this has not been done, because,
3 well, physicians could, in theory, be told "Well, you
4 ought to act this way, not this way". But mostly the
5 answer is "Well, we don't quite know what the legal
6 position is and we don't quite know what doctors might
7 do, and yet we want of course to do the best for the
8 patient." But somehow this grey area is being shied
9 away from and yet seems to be so easy to clear up.
10 I am just wondering what the reasons are.

11 DR. ANDERSON: So you
12 suggest that it is as clear as this, that a firm
13 position one way or another should be taken rather
14 than what is happening now where individual physicians
15 sort of fly by the seat of their pants, and in their
16 attitude toward the problem and society and the
17 person is that they act that way. I think,
18 again, it would be speculation as to how one would
19 actually move into legislation to say either, "You
20 must report all," or "you must not report any," because
21 we ourselves are so divided, as this report shows in
22 our opinions. And it would definitely be very difficult.

23 DR. LEHMANN: But legislation
24 doesn't come into it, it is medical ethics.

25 DR. CAMERON: Excuse me, am
26 I not right in starting from the basis that any
27 citizen being aware of a criminal act in this area has
28 some obligation to report it to the police? I think
29 we are speaking black and white. Certainly the general
30 opinion of the physicians is, the general position is

1 black, and the average physician, as in many other
2 areas with drugs, it can't be black and white. There
3 are shades of grey, some of which he is willing to
4 accept responsibility for.

5 DR. LEHMANN: That might
6 apply later, but if a psychiatrist knows someone is
7 drug taking would you feel he is under an obligation to
8 report him to the police?

9 DR. CAMERON: Another
10 example might be attempted suicide which is a crime,
11 I believe, and there is no question the interpretation
12 of this as a crime is one/which many physicians reserve
13 a basis of professional judgment, and every apparent
14 attempted suicide, they feel, is not properly reported
15 to the police and labelled as a criminal act.

16 DR. LEHMANN: Although in
17 some cases there might be some therapeutic gain if it
18 would be reported. But there seems to be never any
19 therapeutic gain in reporting a drug casualty.

20 DR. CAMERON: One of the
21 specific areas of concern that came up just recently
22 at the Ontario Medical Association is that some
23 physicians working in this area have previously been
24 able to procure analyses of unknown drugs that are
25 endemic in an area which they have experienced in the
26 field that has been of value in the management of bad
27 trips. This locally is, and I believe Dr. Anderson
28 could expand on this, is no longer available because
29 of the constraints of the law.

30 DR. LEHMANN: Well, that is

1 some sort of a compulsion which is somehow not the
2 law, that certain law enforcement agencies seem to use
3 in order to, well, suit their own purpose, and that
4 could be a question I suppose. But because ^{of} the analysis
5 of a drug sample, to have a string attached that,
6 "You must give us, as a price, the name of the person
7 brought in," is another thing; is that true?

8 DR. ANDERSON: I think that
9 is true. Up until recently, the analysis of drugs has
10 been done by a non drug enforcement agency and this
11 was available to physicians or workers in any area
12 depending on who you were dealing with. This is not
13 so now. I think we are waffling badly on this, but I
14 think this gives you some idea how insecure most of us
15 feel working in the area. You have a feeling that
16 Society, with a big "S" which says, "You are dealing
17 with criminals; you are not playing the game; you are
18 not telling us the things we need to punish these
19 people". And yet your day to day experience is that
20 you are not dealing with criminals, you are dealing
21 with young people who you have grown to respect a
22 great deal in a lot of ways, and in some way you would
23 hope society could help because they have difficulties,
24 and if you are trying to make an analogy, say between
25 suicide and other things, that are reportable, if you
26 report an attempted suicide to the police, the things
27 that descend upon that person will not be the same
28 attitude that descends upon a young person who is
29 arrested for possession of these relatively soft drugs.
30 The implications upon him are very severe. He is

1 treated by such mechanisms as the Writ of
2 Assistance with much more harshness than any other
3 offense within our society right now, so that you find
4 that there appear to be many, many more safeguards for
5 someone who is arrested for armed robbery or rape than
6 for a 17-year old boy in possession of a relatively
7 innocuous drug. In you are torn all the time between
8 what you have a feeling you should be doing and how you
9 sort of fly as an individual. I am surely mistaken in
10 many cases, but I don't know how you could spell that
11 out more closely until we move this out of the area
12 of the kind of very harsh law enforcement that it is in.
13 We are trying to deal with a medical problem in a jail
14 situation. If we had to deal with hepatitis, if we
15 had to deal with measles or chicken-pox with the same
16 kind of restrictions, we wouldn't have made any progress
17 anywhere at all, so it is almost hopeless. Physicians,
18 if they can, will opt out of working in this area
19 because they are always sure they are doing the wrong
20 thing. I am always sure I am not doing the right thing.
21 And everywhere you turn you are afraid you are going to
22 betray a confidence to somebody wherever you want
23 information such as, "I wonder what kind of a drug
24 they are really taking that they think is so-and-so?"

25 You can't have that information because
26 there is always some kind of a spectrum of attitudes
27 in your clients that you solidify attitudes against
28 facts because people are thinking attitudes rather
29 than just trying to examine the evidence, so it is a
30 very tough area.

1 DR. LEHMANN: You say then
2 that your medical competence or everyone's medical
3 confidence is killed or stifled and constricted by the
4 legal situation, the legal climate surrounding it?

5 DR. ANDERSON: Very much so;
6 very much so.

7 MR. CAMPBELL: In your brief,
8 you, on one or two occasions used the word "drug abuse".
9 What do you mean by drug "abuse"?

10 DR. ANDERSON: I suppose it
11 is when the drug begins to abuse the person, or when
12 the "drug use" becomes an overwhelming part of the
13 person and they get into problems with its use. In
14 that we are all drug users, all society now in many
15 ways, the terms just saying drug problems, we all
16 probably have drug problems, but drug abuse would be
17 where the habit --- where it becomes a habit which
18 interferes with the happiness or future or performance
19 of the individual, so a chronic alcoholic would be
20 a drug abuser. Someone who used marijuana infrequently
21 for pleasure would not be a drug abuser.

22 MR. CAMPBELL: In the
23 questionnaire that you distributed to the physicians,
24 was there any attempt to define, for instance, phrases
25 like "a bad trip", for you report this rather high
26 number of bad trips on Page 2, bad trips on hallucino-
27 genic drugs, 740 a year.

28 Was the term "bad trip"
29 defined in any specific way or is this a term that
30 was used by physicians in open-ended questions, defined

1 open-ended questions?

2 DR. ANDERSON: Yes. It wasn't
3 defined, it was put in parentheses and probably was
4 understood. There were some other checked questions
5 that do not appear on the summary that we submitted,
6 having to do with patients with drug related problems.
7 I would think that the physicians would know about the
8 bad trip referred to.

9 DR. CAMERON: I think that
10 no one would have any confusion as to the meaning of
11 it. As far as the precise definition, when a good trip
12 stops and starts being bad, I think almost by
13 definition that the patients that come to physicians
14 would be not only ^{on} bad trips but maybe some of the
15 very far out --- very bad ones.

16 MR. CAMPBELL: These could
17 be taken then as instances where the primary reason
18 for the visit to the physician was a bad trip, it
19 wasn't the kid, say, coming in for his annual school
20 check-up and saying I had a bad trip two months ago?

21 DR. ANDERSON: This would
22 be an appearance for an acute purpose which might be
23 just a panic state or it might be a psychiatric ---
24 or it could have been an overdose, it could have been
25 anything, but the general overall garbage can character
26 would be a bad trip, but I think the acuteness or the
27 fact that it showed up as a drug problem primarily is
28 the thing.

29 MR. CAMPBELL: Have you got
30 a copy of the questionnaire that you used?

1 MR. STEIN: What would you
2 have used regarding the desirability of a compulsive
3 treatment for drug abusers as you have just defined
4 them; compulsory medical treatment?

5 DR. ANDERSON: Compulsory
6 medical treatment might temporarily get them off
7 drugs, if that was the goal, but the long-term value
8 of such treatment probably is almost zero.

9 MR. STEIN: What is the
10 reasoning behind that?

11 DR. ANDERSON: Well, okay,
12 you have a young person who is strung out on speed and
13 you admit him to hospital, and you mainly and gradiently
14 de-toxify him and he is within the closed system and
15 everything is fine and you discharge him as cured, and
16 you discharge him back to the same family, to the
17 same society, to all the factors that forced him into
18 this method of opting out. So within two weeks you
19 just wasted this time in the hospital, so fractioning
20 this deal into little tiny pieces and say "Okay, we
21 will look after him medically, we will look after this
22 kid in here, we will look after everything."

23 MR. STEIN: What about
24 compulsory psychiatric treatment, do you believe
25 there is such a ---

26 DR. ANDERSON: I don't
27 believe you can shrink somebody that doesn't want to
28 get shrunk.

29 MR. STEIN: What do you
30 think --- is there anything in your estimation that

1 is a viable kind of treatment response to this
2 situation, be it a voluntary one or a compulsory one?

3 DR. ANDERSON: Okay. I think
4 as you would do with an adult with alcoholic problems ,
5 you would try as much as possible. I think if you were
6 a wise therapist, to ignore the drug, if possible,
7 completely and try to deal with the personality of
8 the person and the factors and his background and the
9 things that led him, unlike his colleagues that were
10 using drugs safely and without getting into troubles,
11 that led him into a problem pattern where he was
12 identified by society as a problem. This is another
13 area where the legal thing is such a restraining thing,
14 that, you know, it took many years for a personality
15 to form, that is, going to end up needing the opt-out
16 type of pattern that you see in drug abuse and you
17 know that it is going to take a long while for people
18 to work with and around this person to change his
19 environment and to see that he will become happy and
20 different. And yet we know that you can't take time,
21 because this kid you are trying to work with is also
22 being watched by the constabulary, and if you move too
23 quickly you are going to lose him. If you move too
24 slowly he will be caught because his --- the caution
25 that one would ordinarily use in hiding an illegal
26 act you are dealing with, no longer applies. Almost
27 all kids who get arrested in this area, I think, want
28 to get arrested or are incapable of hiding their
29 actions. In this respect you will see case after
30 case and there is just no other explanation. A great

1 deal of staff and skill is not required to catch them,
2 and so to go the complicated way around, I think you
3 can say you can possibly ignore drugs as the problem
4 and look at drug abuse as a symptom of a disordered
5 life and problem that he wasn't able to cope with.

6 MR. STEIN: If that is the
7 most likely way to relate to the individual with
8 drug abuse symptoms, do you then see any point at all
9 in the development of specialized treatment centres
10 or treatment services that stand apart from the social
11 services in the community or medical services, to relate
12 to this phenomenon?

13 DR. ANDERSON: I would say
14 yes and no. I would say that, the best of all possible
15 worlds, these young people should not be set aside
16 as being all lumped together as one problem because
17 it modifies itself with drugs. I think the major
18 reason for centralized facilities is because it is
19 very difficult to change attitudes of people within
20 existing circumstances and a central facility might
21 at least help to ensure that, the people dealing with
22 the young person would do so to make them better
23 rather than worse.

24 THE CHAIRMAN: In other
25 words, ^{by} a central facility, you mean a special, large
26 facility?

27 DR. ANDERSON: Yes, even
28 if it did not handle all these things that happen in
29 the community, even if its main function is coordinating
30

1 and educating those other areas, there could be a fair
2 case made. I think, for the fact that we do not have
3 rehabilitation facilities in communities for those
4 who have particular problems. It is a fallacy to think
5 that you could scare the dickens out of him, get him
6 to stop using drugs and say, "okay, get right back into
7 society. Everybody will love you and educate you and
8 give you a job." This doesn't happen and I think this
9 is one area where all of our present methods are not
10 working very well to help.

11 THE CHAIRMAN: Well, would
12 some of the medical problems not still have to be
13 handled in general hospitals?

14 DR. ANDERSON: Yes.

15 THE CHAIRMAN: So you can't
16 get around the need for a change of attitude in the
17 general hospital environment?

18 DR. ANDERSON: Yes, this is
19 a major problem.

20 THE CHAIRMAN: And these
21 specialized facilities would, I suppose, do some
22 emergency work, rehabilitation and follow-up, and sort
23 of a wide, general, oversight and understanding? They
24 would have to work with general hospital facilities?

25 DR. ANDERSON: A central
26 facility could not be a walled-off area from the life
27 of the community anyway, whether the medical life or
28 the other life. They can't be kept walled-off like this.
29 This would have to be a voluntary area where the young
30 person would go to and where he would have to be free

1 to come and go as he saw fit.

2 THE CHAIRMAN: Is there
3 anything like a street clinic in this area - there is
4 some medical service being given on emergency basis,
5 not just referral service --- anything of that kind
6 here?

7 DR. ANDERSON: There is a
8 crisis intervention unit, yes. It deals with all
9 types of emergency problems.

10 THE CHAIRMAN: That would
11 be, I mean ---

12 DR. ANDERSON: This is in
13 the hospital setting as well.

14 THE CHAIRMAN: You said a
15 hospital setting.

16 Well what other things ---
17 getting close to the relationship between the crisis
18 intervention facility and what would still be required
19 from the general hospitals, what can be put in what?
20 From a medical knowledge point of view, what can
21 be put in a crisis intervention centre for the manage-
22 ment of medical problems as such? To what extent
23 could it become a reasonably efficient self-contained
24 medical unit?

25 DR. ANDERSON: The crisis
26 intervention centre?

27 THE CHAIRMAN: Yes.

28 DR. ANDERSON: The crisis
29 intervention unit is really an emergency service and
30 we are there to deal with problems as they come out

1 and farm them out somewhere else, and this is where
2 I think, in the drug area, the crisis intervention
3 centre breaks down, that you may be able to cope with
4 them there, but the follow-up, channelling them into
5 areas where they can get help, is lacking.

6 MR. CAMPBELL: How do you
7 feel about the role of non-medical personnel in
8 handling a drug crises --- we have heard a good deal
9 of testimony about the role of young people coping
10 with drug crises of other young people in apparently
11 highly effective ways. Is this a type of activity
12 that you feel should be encouraged?

13 DR. ANDERSON: It depends
14 on the young person doing it I don't think there is
15 any magic about a young person to talk down a person.
16 In fact, very often when you encounter a group in
17 which one person is having a bad trip, very often you
18 will find that his colleagues have helped contribute to
19 that and many of the manoeuvres and hocus pocus around
20 talking somebody down, in fact, intensifies reaction
21 rather than cools it, and so I think we are starting to
22 get a new little medical mystique around the witchcraft
23 of the street just like we got the witchcraft about
24 the white coat, and coming in with a stethoscope and
25 popping some pills into the kid. I don't think it
26 is all easy and nice either and I don't think there is
27 any special reasoning in being sick yourself and saying
28 you can help somebody else.

29 DR. LEHMANN: On Page 5 you
30 mentioned strong opinions which are expressed by some

1 respondents, for instance the abuse of amphetamines,
2 barbiturates by middle-aged housewives, is more important
3 than the drug habits of the teenage children. We hear
4 this very often and it is often expressed in the
5 medical literature. How would you view this statement
6 as simply a statement that --- to put things into
7 perspective so that one does not over-dramatize the
8 problems of the children of these housewives and
9 consider them equally important if not more so, or do
10 you view this as a signal on education that there is
11 desperately needed some better and more treatment for
12 these middle-aged housewives?

13 DR. ANDERSON: Both of
14 those, and perhaps even more. Putting it in context,
15 the hypocrisy of adult society which just admits drug
16 abuse is only what young kids are doing with drugs that
17 we don't happen to use and ignoring the fact that as
18 drug abusers, the young kids win no prizes at all,
19 and the fact that we always castigate the drug that
20 we don't use ourselves. And the fact that the drugs
21 that the housewife is using are legal drugs, that are
22 prescribed legally, brings up the second point; the
23 fact that we have to examine ourselves in a society
24 as physicians and really think what we are doing when
25 we take the easy way out by finding a chemical way to
26 deal with a difficult patient, and finding a chemical
27 way to deal with a difficult life. And although we
28 try to change the life style of the young people and
29 try to mould them the way we want, we find ourselves
30 that when we are getting into a life style pattern

1 we can't hack very well at all, we will take tran-
2 quillizers so we can adapt to the style rather than
3 change things around. And so it is critical with
4 both of these areas screaming one set of signals, but
5 if you look at this, we are doing it in a different
6 way. And drugs have been an easy way to deal with a
7 lot of complicated things and we are starting to reap
8 the benefits of it now.

9 DR. LEHMANN: "Benefits,"
10 you mean, in quotes?

11 DR. ANDERSON: Yes.

12 DR. LEHMANN: Well there
13 would be three sorts of problems then--- the younger
14 generation and illegal drugs and alcohol, of course,
15 which we all know is a huge problem, and then here
16 what one might call the heterogenic drug abuse. Now
17 there are special centres being promoted and being
18 created for the younger generation and special centres
19 exist for a long time for the treatment of the alcoholic.
20 Do you conclude that there ought to be special
21 treatment centres or more facilities for the adult
22 who will require a good deal of psycho-therapy for
23 instance, rather than constant tranquillization or
24 euphoria-producing agents?

25 DR. ANDERSON: Perhaps
26 prevention would be a better area to get into. I don't
27 know if there is much hope with drugs for someone who
28 has for a whole lifetime used them as crutch and without
29 the crutch you have alot of troubles, and I think the
30 responsibility of a person who takes drugs away from

1 somebody, you have to realize that you are responsible
2 for what happens next, and maybe we need huge education
3 --- it sounds very corny and naive --- in life styles
4 and start teaching people how to cope with calamities
5 in non-chemical ways.

6 DR. LEHMANN: It would mean
7 that the doctors would have to spend a great deal more
8 time and, well, some sort of counselling or therapeutic
9 ---

10 DR. ANDERSON: It may mean
11 that the doctor would have to realize that when Mrs.
12 Jones comes in and she is all spastic that this is
13 not a medical problem and it can't be --- it can be
14 solved better by giving a chemical but the physician
15 has to work more and more with the rest of society
16 and the rest of the community to help people cope with
17 these problems in non-chemical ways.

18 DR. LEHMANN: So you would
19 then have psychogenic, sociogenic and heterogenic forms
20 of drug abuse?

21 DR. CAMERON: It is hard
22 to say but I think undoubtedly physicians have suffered
23 from the pressures of the expectations of patients,
24 of receiving a chemical answer for a particular
25 problem. The Thalidomide tragedy has perhaps reduced
26 that pressure. The general medical attitude is to
27 continually examine our own therapeutic happenings
28 and minimize the use of drugs.

29 DR. ANDERSON: If I may, I
30 have a copy of a letter from a Foundation that deals

1 with the residential psychiatric care of young people.
2 This letter came to our attention through the
3 questionnaire that was sent out to one of the
4 physicians and the letter is as to the type of
5 treatment given and the relative successes and it

6 says:-

"We have been more success-
ful in our treatment of
young people with purely
defined emotional illness

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--- Quote unintelligible

1 THE CHAIRMAN: Doctor, on
2 Page 5 of the brief there is a quotation, some of
3 the answers perhaps in the questionnaire ---"we should
4 abolish the sale and manufacture of amphetamines
5 completely". What do you think would be the general
6 medical opinion as to retaining amphetamines for
7 medical prescription? Would this be regarded as
8 feasible, remove amphetamines completely from our
9 medical armoury?

10 DR. CAMERON: It is interest-
11 ing that the general practice of the Hamilton Medical
12 Academy has formed a resolution to this effect to the
13 Committee on the Non-medical Use of Drugs. I think
14 that this should not be interpreted as an unanimous
15 but a majority opinion of those physicians interested
16 to take part in this position.

17 THE CHAIRMAN: To the O.M.A.?

18 DR. CAMERON: Right.

19 THE CHAIRMAN: When was
20 this sent?

21 DR. CAMERON: I think about
22 three or four months ago --- I could check that ---
23 and they have interested themselves in this question
24 too --- the Pharmacy Committee of the O.M.A.

25 DR. LEHMANN: This recommen-
26 made
27 dation has been/by the majority of the physicians in
28 general practice, you say? Does that not constitute
29 some sort of an admission of defeat for the physician?

30 DR. CAMERON: I am glad
that you gave me a chance to amplify this. The

1 recommendation, as made, I think is a better measure of
2 the concern of the physicians --- my personal opinion
3 is --- rather than a realistic solution.

4 THE CHAIRMAN: An expression
5 of concern rather than a realistic solution?

6 DR. CAMERON: And
7 significantly this is not the result of an exhaustive
8 study but more a concensus of opinion.

9 DR. LEHMANN: I note there
10 is a recommendation for more family treatment centres.
11 Is this related to the fact that McMaster University
12 has particularly strong emphasis on competence and
13 expertise in family training?

14 DR. ANDERSON: No, but I
15 think it is fortunate that it has. It is certainly an
16 area where prevention and positive planning is far more
17 important than dealing with the catastrophes of
18 family pathology.

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--- Portion unrecorded.

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1 and enjoying his work and doing a competent job and
2 doing it so well that he watches being promoted into
3 the areas of management and into the moving of paper
4 across a desk and the dealing with personnel in which
5 he is not skilled or trained because he was doing so
6 well on his original job, and he goes out and he
7 watches his father on the first trip to the doctor
8 with the ill-defined pains in the stomach and he
9 watches the tranquillizers begin and he watches his
10 father cope chemically with an alternate life style
11 that he doesn't really have to follow.

12 THE CHAIRMAN: This is a
13 father who was the victim of Peter's Principle?

14 DR. ANDERSON: That is
15 right, which most fathers are, and the kids say he
16 knows what he would do.

17 THE CHAIRMAN: He is not the
18 only one.

19 DR. ANDERSON: And he knows
20 what they are, why does he stick to it, why does he
21 take this very lousy life plus the chemicals needed
22 to have it?

23 THE CHAIRMAN: But it has
24 been brought home to us that a lot of drug use to-day
25 is associated with change in life styles by young
26 people, so that's what I was wondering if you had in
27 mind because there is a different life style associated
28 with a lot of drug use by young people. What change in
29 life style, insofar as they are concerned could be
30 regarded as an alternative to drug abuse?

1 DR. ANDERSON: I don't know,
2 but certainly life style changes tend to be linked
3 with drug use in young people, but in part I think
4 that it may be just accidental that drugs happen to be
5 there. For very many young people the drug subculture
6 is a crucial part of their life, a real need. It is
7 not because there are drugs in it but because there are
8 a group of people who are linked together for some
9 purpose and they need the support of this small group,
10 and this is showing up more and more now as the months
11 go by. The life styles as alternatives to drug abuse
12 I suppose, would fall into the general category of
13 non-chemical turn-ons and it gets a little hocus pocus,
14 but people^{who}/generally advocate non-chemical turn-ons
15 are talking about real life experiences and the
16 satisfaction of true personal inter-relationships; the
17 satisfaction of having a future that looks good; the
18 satisfaction of doing something that you and other
19 people can appreciate as being well done.

20 THE CHAIRMAN: Well, the
21 young people say --- I would think that they would
22 express it this way, that it's not so much as a change
23 in a life style on our part that is required, it is a
24 change in the social conditions and in the nature of
25 the personal relations. But what about the natural
26 high? As a physician, in speaking with the sense of the
27 collective experience of your body, have you had any
28 observations about the relationship between these
29 factors that we are asked to look at, the social con-
30 ditions, and when we speak about philosophical factors,

1 the relationship between the social concept today and
2 drug use and the related difficulties that you have
3 to deal with as a physician.

4 DR. ANDERSON: Well, here again
5 you can fall into the trap of, you know, playing
6 instant philosopher.

7 THE CHAIRMAN: It is difficult,
8 but we are asked to look at it.

9 DR. ANDERSON: I would not talk
10 in a sophisticated way perhaps, but I could only
11 tell you the kinds of things that seem to be crucial
12 in the development of alienation patterns in these
13 young people I deal with, so this becomes perhaps not
14 as grandiose as it might have been. But the thing,
15 number one, in the alienated, affluent middle-class
16 young person sees the attitude that society has
17 towards education as the only key to success; and
18 happiness in the future. In fact you are told if
19 you don't have a University education, you are a
20 failure whether you have the ability or the aptitude
21 or the interest or whether you have another kind of
22 goal which doesn't require an academic application.
23 So we are forcing more and more the young people,
24 whether they want to or not, "for their own good",
25 into a very big business of educational establishment
26 which is killing itself to adapt and to do as well
27 as it can to educate people who don't want to be
28 educated. And the more it fails, the more we look
29 for technology to produce. You know, put a
30 computer in the school, and

1 everybody will love you, and we are breeding an alienated
2 group just from this one factor alone, and it isn't the
3 educational establishments' fault. It is our fault as
4 parents and as a society which has built this myth.
5 The Union Leader with a Grade Nine education who says,
6 "We won't take any apprentices in our programme unless
7 they have a Grade Twelve education," you know, sins
8 as much as the father who is a doctor and wants his kid
9 also to go through the same pattern, so we are all doing
10 it and kids become very conscious themselves as
11 potential failures pretty early on, and it is hard to
12 fight. That is just one of the kinds of things that
13 we find contribute to it.

14 THE CHAIRMAN: Dr. Lehmann?

15 DR. LEHMANN: Does it
16 happen to you, Dr. Anderson, that a mother calls up
17 and very excitedly tells you "Doctor, I just found out
18 that my son is smoking marijuana, so he is very sick,
19 so could you see him," and then wants to make an
20 emergency appointment. And what would you tell her?
21 First of all, would you see her son or daughter?

22 DR. ANDERSON: Yes.

23 DR. LEHMANN: And then?

24 DR. ANDERSON: Well, I would
25 --- I don't think I can generalize.

26 DR. LEHMANN: No, I know.

27 DR. ANDERSON: But, I
28 suppose in general terms you would want to see --- it
29 is the worst possible setting to see a young person
30

1 when they are carried in screaming and kicking and
2 accused by their parents of doing a bad thing, so
3 your chances of establishing any rapport with the kids
4 are about zero or just about zero
5 on the first bounce. Your major responsibility as a
6 physician at this stage is to (a) evaluate the
7 situation to see whether it is just a little innocent
8 acting out and no sweat and (b) to cool it, and so
9 that the parent and child can look at this in a
10 rational way to see if it is a problem or if it is not
11 a problem. But what happens from there would depend.

12 DR. LEHMANN: It is always
13 a problem because it is a legal problem, but what I
14 was aiming at is the assumption by so many parents
15 that if their child is smoking grass, well, that it
16 goes without saying he is sick, and they simply will
17 not accept the fact that he may have a problem or
18 they may have a problem in the family, but it is not
19 the physician's responsibility because smoking pot
20 and being sick is not a problem.

21 DR. ANDERSON: We said this
22 before, the impossible situation the physician is
23 placed in because when you say there is not a darned
24 thing wrong with this kid at all, and yet if the
25 mother looks you in the eyeball and says "What do
26 you mean, he is doing an illegal thing". What would
27 happen now if you called the police? Well, he would
28 be booked for possession, is that serious? Of course
29 it's serious, so how can you, as a doctor, say it's not
30 serious, so you end up in this big hang up. I think

1 if the dangers of, okay, this report shows that even
2 among a relatively up-tight group such as we physicians,
3 they have scored marijuana lower than cigarettes and
4 lower ^{than} alcohol in severity, but how responsible is
5 that a thing to say, when we say "Okay, marijuana is
6 a relatively innocuous drug" which it is. We are
7 not the ones to get busted. We say this to the kids;
8 they are the ones that are getting the troubles, and
9 until we change this it makes it impossible to deal
10 rationally with the mother and her kid and the society
11 and everything else. We can't use the scientific
12 knowledge, such as it is, that we have without hurting
13 people further including ourselves, and a lot of
14 doctors are pretty scared to get into this area because
15 they are just not sure of what is going to happen to
16 them. So you can't deal with medical things like
17 that.

18 MR. CAMPBELL: Bearing in
19 mind that these physicians have rated alcohol as a
20 potentially more dangerous drug, and bearing in mind
21 that while there was a great deal of public attention
22 to cannabis and other use by young people, there is
23 surely also the fact that a great many people in high
24 school and elementary school also use alcohol. Do
25 you, in terms of your practice and what you hear from
26 your colleagues, regard alcohol use as a notably serious
27 drug problem among adolescents and other young people?

28 DR. ANDERSON: Well, the
29 dangers medical and social of alcohol are well known.
30 We have just grown to accept that a certain percentage

1 of our population is going to die directly or
2 indirectly by the use of alcohol, and we just sort of
3 say "Okay, that's the way it is." Certainly there are
4 social pattern correlations between the type of drug
5 used in the teenage years as we all know, and if you
6 survey a large enough community you will find pockets
7 where alcohol is the drug choice and others where the
8 hard drugs are the drugs of choice, and other areas
9 where cannabis and the chemicals are in general use.
10 So just as individuals choose the drug that gives them
11 the effect that they want, you get the feeling that
12 pockets, socio-economic pockets in people, also have
13 a drug of choice which fills their collective ego, I
14 suppose. So my crystal ball isn't working very well
15 at the moment, but I would guess we are moving into
16 the next area, in which there would be a variety of
17 drugs and each would have its set of problems and each
18 would have its own set of people that used them, and
19 alcohol would probably continue to be a problem, but
20 it won't be a problem for all kinds of people.

21 MR. CAMPBELL: Let me raise
22 two questions, then, out of that. If we hypothesize that
23 alcohol, up to a few years ago, was the main psycho-
24 active drug used in this population, any population,
25 non-medically, and let's say that a proportion of 'X'
26 percent as a population that has the availability of /
27 come to use alcohol, and then we come to the use of
28 other drugs, and, do you think the use of those
29 other psycho-active drugs will increase that proportion
30 who abuse drugs, that proportion of the whole population,

1 or would your feeling be that that proportion would
2 remain more or less constant but would divide among
3 various drugs?

4 DR. ANDERSON: I think the
5 latter. This becomes a bit conjecture, you know, but
6 I think the difference in society, the 'X' percent of
7 the population are almost certain to include people
8 to whom alcohol would be a trauma but they also include
9 people in whom any kind of trauma or any kind of setting
10 is going to produce a breakdown in living of some
11 sort, perhaps, and what we are seeing now is maybe the
12 fact that the spectrum of drugs available to cause
13 trauma in this area are causing people to have break-
14 downs in living, younger than they used to, so that
15 perhaps we are not increasing calamities at all, it
16 is just the gal who at thirty-five was going to have,
17 the first time, psychosis, instead she is now
18 freaking out at age eighteen on one of these drugs
19 so that we are picking the vulnerable element of the
20 population.

21 The fact that drugs are
22 going down to this younger level, getting them
23 earlier---that is conjecture, but the fact that we
24 are perceiving the gulf of drug use going up and
25 yet the gulf of drug problems going down suggests
26 that it is a population with the increased drug
27 problems and now just as the kids become old enough
28 to get into this, from thirteen to fifteen to sixteen,
29 the younger ones will be involved so we will pick
30 the vulnerable ones as a population and put them out

1 --- I would guess.

2 MR. CAMPBELL: Could you
3 expand a little bit more on the selection of drugs
4 by various populations and the differential motivation
5 to various drugs? You have mentioned the factor of
6 social class, socio-economic class --- it was
7 mentioned to us yesterday, again, the tendency of the
8 younger person perhaps to use solvents. I think the
9 statement was made yesterday of the progression from
10 solvents in the pre-teen years to chemicals in the
11 lower high school years, to cannabis in the higher
12 secondary school years --- but generally would you
13 expand on this differentiating motivation?

14 DR. ANDERSON: I think you
15 can only give this in pieces. Generally, I think the
16 solvent using in young people, in the very young
17 people is --- they choose it as a drug because it
18 is accessible to them because^{of} the low income sub-
19 culture where the other drugs are accessible.

20 Secondly, it is sufficiently razzle-dazzle that they
21 can get their parents' attention in a hurry and they
22 always leave tubes and bottles and plastic bags and
23 things around so it seems to be a very young persons'
24 way to get attention in a real hurry, and
25 besides, even if there were other drugs that he would
26 prefer, he does not have access to them.

27 I have become less impressed
28 with this idea of progression through drugs as time
29 has gone on and I have had enough time to see sort of
30 longitudinally what is going on. At first it sure

1 | looked as if young people went through the whole deal
2 | from cannabis to chemicals and if things were really
3 | tough, amphetamines. But more and more, you see, they
4 | do the shopping centre bit and try all of them, but
5 | for each person there is one chemical or one category
6 | that fits them well. Now I don't know if there ---
7 | there has really not been enough hurt done to make
8 | these definitive things, but certainly the amphetamine
9 | users set a pattern.

10 | MR. CAMPBELL: How do you
11 | see that pattern?

12 | DR. ANDERSON: Invariably
13 | they are individuals who are inadequate in pretty well
14 | everything they have done, their relationship with
15 | their parents when they were little, and generally have
16 | not coped and they fit in this category. Again this
17 | is pretty silly, to make pigeon holes this air-tight,
18 | but as we now are getting more and more we can look
19 | with respect to the very gentle drug subculture,
20 | the relatively shy, the relatively very bright
21 | individuals, probably through late puberty, probably
22 | having some difficulty interrelating with people and
23 | finding a warm subculture to live in where he does not
24 | have to do anything. And the hash using group
25 | occasionally, who may perhaps drop acid on the weekend.
26 | So they almost all look alike and they almost all
27 | talk alike, and when you look at their backgrounds,
28 | you can see this is a very comfortable group that they
29 | have come into. So this kind of pattern is starting
30 | to show up.

1 THE CHAIRMAN: Are there
2 any ---Yes?

3 THE PUBLIC: If a Speed
4 freak went to the crisis clinic, how would they handle
5 him, put him in cold turkey and cut him off every
6 drug, or would they use the New York method of cutting
7 him down slow?

8 DR. ANDERSON: I can't
9 guarantee what would happen at a specific crisis
10 intervention place, but I think the best medical
11 opinion would have him admitted to hospital and he
12 would not be treated cold turkey. He would be taken
13 down slowly.

14 THE PUBLIC: So if a wino
15 came to you, would you recommend a drug like marijuana
16 to him to cut him off alcohol?

17 DR. ANDERSON: No, I would
18 want to get to know the man. I wouldn't be interested
19 in the wine he was consuming, I would be more interested
20 in the person who was consuming this wine. And I
21 would probably be defeating my purpose if I just
22 tried to substitute one drug for another. I would try
23 to worry about him as a person.

24 THE PUBLIC: Well, a lot of
25 doctors didn't mean this.

26 DR. ANDERSON: Yes, I think
27 I know that is true.

28 THE CHAIRMAN: Yes?

29 THE PUBLIC: Has there ever
30 been any research into marijuana and hashish as a

1 tranquillizer as replacement for some of the more
2 prevalent types such as librium I suppose, or even
3 some of the barbiturate group?

4 DR. ANDERSON: Within the
5 period of time that people have been researching this
6 area, marijuana and hashish have not been available to
7 the medical profession for research or any other
8 purpose.

9 THE CHAIRMAN: Yes? Gentleman
10 at the microphone?

11 THE PUBLIC: To the doctors
12 in the medical profession, do you see the drug use as
13 a problem itself or as a symptom of the real problem?

14 DR. ANDERSON: In the report
15 it states that drug abuse is a symptom of diseases.
16 We can't underestimate the fact that drugs per se,
17 any drugs can cause troubles, just about any drug can
18 kill you. But most of the things that we are
19 labelling right now as the drug problem is not a
20 drug problem. It is a problem within society or
21 within an individual who may want to hide behind the
22 bad things in society to explain his own inadequacy
23 from time to time. But there are enough rotten things
24 going on within ourselves and our communities to
25 explain an awful lot of reasons of why we want to
26 opt out. The drugs are the symptom in most cases
27 rather than the disease.

28 THE PUBLIC: That is the
29 way I see it. The way I see it is the problems are
30 through our society, our family or just a general--but

1 the general Inquiry was prompted, I think, by getting
2 upset over the kids taking drugs, not the fact that
3 kids are up-tight about these things and the drugs
4 are only reaction to this. And I just hope that the
5 Inquiry realizes that the drug is not the problem, and
6 I hope you don't react negatively to it by increasing
7 the laws and so forth, because the drug will never be
8 replaced that way; it will only be isolated. I think
9 if you wanted to defeat the problem or change the drug
10 use, I think you have to do something positive. You
11 have to make life for Canadians and Americans and
12 people all over the world better so they don't have
13 to escape. And, I mean marijuana, I think it is pretty
14 plain to everybody that if this world was going to
15 be the "Brave New World like in Aldous Huxley it is
16 going to be the Soma. It is going to be thing to
17 come, it is going to have to be legalized. I don't
18 see any way of getting around it. And as far as
19 the harder drugs, like heroin and so on, it is a
20 different scene altogether and that is completely
21 different from marijuana. I don't think they can be
22 lumped together again because they are two different
23 things. The kind of person that goes in for heroin
24 and the kind of person who goes in for marijuana are
25 two different kind of people. And what I want to
26 wrap up, is just to say that I hope you don't look
27 at drugs as being the problem but only a symptom of
28 the problem. The real problem is our society and
29 the way we live. And like these couple of men that
30 were here yesterday from the Trade Unions, that

1 | figured that a lot of kids were going into this because
2 | they were poor or something, because of the standard
3 | of living. They seem to think of the standard of
4 | living as being the scale. Well, that is not important
5 | to people, it is not the standard of living, it is the
6 | quality of living. I think the Eskimos and Indians
7 | have a quality of living that nobody in this room has
8 | --- the same quality of living. The standard was so
9 | low compared to us and I think we have to capture their
10 | quality of living, and we would not have these kind
11 | of problems. There would not be an abuse problem with
12 | drugs, there would be just getting along.

13 | THE CHAIRMAN: Thank you.
14 | The gentleman behind --- can you reach the mike?

15 | THE PUBLIC: You mentioned
16 | before a certain amount of concern for the fact that
17 | you can now have analysis of Speed --- drugs. However,
18 | you did not make any recommendation on this. Would
19 | you suggest a medical centre be set up for analysis
20 | of drugs in treating of bad trips and things like that?

21 | DR. ANDERSON: The recommenda-
22 | tion wasn't made because it did come out of the survey
23 | and we had a relatively restricted guide --- we just
24 | chose to do this as our submission, and this is what
25 | we did. But there is already a laboratory facility
26 | through the Ontario Addiction Research Foundation to
27 | test drugs and they were doing this up until relatively
28 | recently, so it would not require setting up any
29 | mechanism. The mechanism is already there for analysis
30 | and the material. It would be nice to be able to

1 resume that programme without fear of difficulties ---
2 like having the lab technician busted for possession.

3 THE CHAIRMAN: Excuse me,
4 if I might just get this on the record. As doctors,
5 you feel that such a facility is an important aid for
6 treatment purposes --- you would say it is an essential
7 aid?

8 DR. ANDERSON: Oh yes, you
9 are flying blind --- you can't deal with a chemical
10 problem if you are not allowed to know what the
11 chemical formula is.

12 THE CHAIRMAN: Excuse me, I
13 didn't mean to touch off ---

14 THE PUBLIC: That was more
15 the question ---

16 THE CHAIRMAN: I just want
17 to get this on the record because it has become quite
18 an important issue in our inquiry. The question
19 has been posed about the possibility,
20 the actual utility of such a facility for specific
21 cases of treatment. In other words, the drug had been
22 injected, let us say, or taken--if you are smoking it
23 --- so the actual thing that is causing the difficulty
24 is not subject to analysis. There has been a question
25 raised of just how useful it is in relation to the
26 actual treatment of a particular case --- the time
27 problem, what is your view on that?

28 DR. ANDERSON: The time
29 needed would perhaps not make it feasible for the
30 treatment of the individual although a great deal now

1 might be done on spot testing on admission to hospital.
2 This has not been developed, because we just do not
3 have centralized facilities where you have a high
4 case load of patients coming in, and so in acute
5 treatment, almost certainly, it would be a matter of a
6 very short period of time to work out these technical
7 problems --- spot testing to identify, for instance,
8 the difference in the chemical group where
9 it might alter your decision of the drug that you
10 would use on the person who is in difficulty. The
11 major argument against testing street drugs that is
12 raised is the fact that it was serving as a quality
13 control mechanism for dealers. Now, I suppose, it is
14 hocus pocus; you might say that that is in fact true.
15 However, it does seem terribly dumb to me to have some
16 kind of quality control if the drugs are being used.
17 The fact that we have not stopped testing them is not
18 decreasing the amount of drugs on the street, it is
19 just that we have no idea what is being passed around.
20 I am sure you saw the Ontario Addiction Foundation
21 reports of the analyses done during the previous year
22 to see the fact that many chemicals that were --- many
23 drugs that were sold were not in fact what they were
24 said to be, they had impurities and so on and it is
25 very vital to have this kind of quantitative control
26 when you are dealing with a volume of patients to say,
27 "Okay, this is what happens," and those kids were using
28 pretty fair acid. These kids thought they were using
29 so and so; they were using so and so. And to be able
30 to have an effective way of warning people --- it does

1 not seem really that dumb to me to say "Okay, that is
2 bad stuff." Even if it is an illegal thing, it doesn't
3 seem terribly stupid to save the odd life if you
4 can in this method.

5 THE CHAIRMAN: Thank you.
6 Yes, could you reach the microphone?

7 THE PUBLIC: Both yesterday
8 and today the attractive and innocuous qualities of
9 marijuana have been pointed out quite forcibly, and
10 the fact that it should be differentiated legally
11 in its use and distribution. Yesterday I asked a
12 question of a young man from Lorne Park Collegiate
13 if they could foresee any possible problems or need
14 for treatment arising from marijuana by itself.
15 Whenever anyone talks about the need of treatment for
16 drugs, they always lump drugs as a group, when they
17 speak about Speed, heroin, etc. I would like to know
18 if you gentlemen can see that heroin in itself has a
19 potential for any damage ---

20 THE CHAIRMAN: Excuse me,
21 did you mean to say marijuana?

22 THE PUBLIC: Marijuana, yes.

23 THE CHAIRMAN: You said
24 heroin, in itself.

25 THE PUBLIC: Oh, I am sorry.
26 Thank you. That marijuana in itself has a potential
27 for any damage, physical, psychological, biochemical
28 to one individual. I think we are on very dangerous
29 grounds when we are advocating this as a very
30 attractive and innocuous thing to use. We are saying

1 it is different from everything else, we are saying
2 treat it differently, and yet are we facing the fact
3 that there may be possible danger to its use?

4 DR. ANDERSON: Certainly I
5 don't think this report in any way was trying to
6 show marijuana as an attractive drug, so certainly
7 we are not pushing. I think we are showing that
8 compared to alcohol, which is a known killer of
9 people, their minds and their lives and everything,
10 for those who are susceptible to it, that they are not
11 arrested, they are not treated, you know, as a diseased
12 part of society in the way that --- compared to
13 all the other drugs on the list, and we have had some
14 thousands of years of experience in seeing the effects
15 of the cannabis group, it is not the problem, and it
16 does have effects, but certainly compared to all the
17 others we have no evidence of mortality and the
18 (morbidity) is pretty low. The only kinds of things
19 that you generally see with, say, marijuana alone,
20 are those individuals who have problems in life that
21 they are trying to run away from and marijuana provides
22 a very helpful, quiet environment to do that and so
23 they may get into difficulties --- social difficulties
24 because they opt out of things that society wanted
25 them to do, but we just don't see anybody in medical
26 troubles with cannabis.

27 THE PUBLIC: No bad trips.

28 DR. ANDERSON: No bad trips.

29 Again you would have to define what you meant by that,
30

1 but no, it is not that sort of thing. You see, we tend
2 --- it isn't so much that a lot of people are saying
3 it is a good drug, as so many people are lumping it and
4 saying it is a bad one. Like there is not much ---
5 people don't look at the evidence --- did I do a bad
6 thing? I did a bad thing. What did I do?

7 THE PUBLIC: I just feel that
8 there are a lot of people in this room who think anybody
9 who criticizes marijuana is out of their head, that we
10 are being completely subjective and emotional if we
11 even suggest that it might effect the way --- the way
12 in which your iris is adjusted, the ability to make
13 fine distinctions, to have muscular coordination, that
14 you might have hallucinations four days after taking
15 a marijuana trip, that all these things, these are all
16 documented scientifically, documented facts. Maybe you
17 haven't read any of the literature. It might be a
18 good idea.

19 THE CHAIRMAN: I notice,
20 doctor, if I might just observe --- because we have
21 the brief and others don't, but I notice that the scale
22 for the ranking of these drugs according to relative
23 potential for harm runs from one to seven. One is
24 extremely dangerous and seven is harmless and marijuana
25 is the last on the scale, but it is given the rating
26 of four, so that it is not given a rating of seven as
27 harmless. I merely point that out.

28 DR. ANDERSON: There are
29 no chemicals that you take into you that are harmless,
30 none, zero. I think the total irrationality of dealing

1 with someone who uses --- or dealing with marijuana as
2 a substance proves --- many of those papers are not
3 as scientific as they appear to be. In the recent
4 edition of Addiction produced by A.R.F., there is a
5 little --- have you seen it, and it just came out,
6 pointing out that some of the studies quoted have not
7 been that valuable and there have been --- there hasn't
8 been much done in the last while, but within the last
9 year and a half there have been studies shown comparing
10 cannabis effects opposed to other drugs on coordination,
11 etc., etc. And it would be silly to say cannabis doesn't
12 produce effects on people. That is what it is about.
13 What we are really talking about, does cannabis --- how
14 dangerous is it to ^{health} and life, and when we compare
15 it to other things, how much of a danger is it.

16 MR. STEIN: I wonder if I
17 could direct a question to the young woman in the audience.
18 Given your concern about this, I wonder if you could
19 share with the Commission the reasons for your concern
20 on this point? In other words, did you have any
21 experiences directly or indirectly --- I am sorry, I
22 am directing myself to you --- that would assist us in
23 understanding something more about the effects of
24 marijuana? In other words, you have expressed on two
25 consecutive days some very genuine concerns about the
26 effects of the drug. Is there some other reason other
27 than what you have read in the literature that raised
28 this concern?

29 THE PUBLIC: I am going to
30 be a member of the Committee that is presenting a brief

1 this afternoon which deals with this, and I think
2 perhaps that would be better.

3 MR. STEIN: Fine.

4 THE PUBLIC: I just say
5 that I do --- I am impressed by the fact that many
6 young people are very enthusiastic about it and I
7 just would like to make sure that they realize that
8 there might be short-term or long-term detrimental
9 effects.

10 THE CHAIRMAN: The lady there--
11 I don't know whether you can reach the mike.

12 THE PUBLIC: I am a mother
13 and I can probably make myself heard.

14 I would like to
15 ask, the question was brought up about changing the
16 attitudes of the staff in hospitals. The many years
17 that we have dealt with mental illness, this was not
18 able to be done, and the mental illness was involuntary.
19 The drug user is saying, "this is my decision", which
20 we respect. But then they expect medical staff to look
21 after them when they get into trouble and the fact
22 that the medical staff resent this, I think, is
23 reasonable. I would like to know how you expect to
24 change the attitudes of the medical staff.

25 DR. ANDERSON: I am not sure
26 that it is the function of someone who is involved in a
27 helping profession to be judgmental about the foibles
28 of human nature and the kinds of things that people do.
29 When a young lady comes in who is irreversibly unmarried
30 and irreversibly pregnant, it is not my function really,

1 I wouldn't think, to make a big gaffuffle and point out
2 that it was in fact a self-inflicted wound, and make
3 a big deal. My problem is to deal with someone who
4 is very frightened and who--anything I can say to
5 them, you know, they already know, they have been
6 through it, I am just seeing it, and my job is to help
7 in that particular thing. So I just questioned about
8 the fact that we as physicians, whether we should be
9 judgmental about the fact that they didn't have to
10 take the drug that caused them to come in. The other
11 half of what you are saying, how do we change attitudes,
12 I don't know whether we all sit around in a circle and
13 hold hands and do nice things to not, but I think one
14 important thing is we have to have people meeting with
15 people with problems and seeing them as individuals,
16 rather than just reading about things or always staying
17 within a circle of people where everyone is judgmental
18 about something, where, suddenly you are accosted
19 and there he is, he is a junkie and he really freaks
20 out, rather than starting in our programme which we
21 hope to do in the community, the continuing education
22 for physicians. I certainly hope that will involve
23 getting physicians who have been involved with young
24 people to listen to them, and to talk with them and try
25 to stop talking about drugs, and start seeing them as
26 people rather than just a circulatory system with some
27 chemicals running around in it, and I think it might
28 happen.

29 THE PUBLIC: I wasn't referring
30 to physicians, I was referring to the staff that take

1 them in, who are human beings and have feelings, and
2 I don't condone the judgmental attitude, I am just
3 saying how can we do something about it?

4 DR. ANDERSON: Well, I think
5 this is the way, it is education with a big "E" but
6 it has to be on a personal basis.

7 THE CHAIRMAN: Yes.

8 THE PUBLIC: What is the
9 doctor's estimation on marijuana, and whether it would
10 be of value or danger in medical use, what are your
11 own views on that, like an independent study or
12 study ---

13 DR. ANDERSON: Again, I can
14 only say that many people find it useful and the
15 evidence --- the scientific evidence about its danger
16 is lower than most of the other drugs that are used
17 in the general area of mood altering drugs. But I have
18 no way of comparing benefits to people as far as
19 mood altering. I can only talk its lack of danger.

20 THE PUBLIC: I would like to
21 point out to the ladies who are asking the questions,
22 they were saying why so many young people were taking
23 marijuana and when they look and see somebody, like
24 the foremost authority in the United States right now
25 in marijuana would be Dr. Paul Goodhart, which I think
26 is the past president of the Student Drug Administration
27 and when the young person would look at him and he
28 would say publicly that he saw no harm in the use ---
29 absolutely no harm in the use of marijuana, and the
30 only reason he would not allow his own children to take

1 it was because it was illegal. I think when young
2 people look at someone in a position which he had, and
3 even their own family doctors are not coming out and
4 condemning it, they would really see no reason why
5 they shouldn't take it. It is almost as if --- not
6 through doctor's work only, but they weren't telling
7 them not to take it and I think some of the problem
8 is with our own physicians who have not really openly
9 denounced it. If it isn't valuable they could not have
10 really taken a stand on it.

11 THE CHAIRMAN: The gentleman
12 there?

13 THE PUBLIC: I mention this
14 and I don't know, I don't think it will shock anybody,
15 but I have been through the sort of trauma of getting
16 busted for marijuana, and, well, actually it is almost
17 --- once you get over the shock of, you know, the fact
18 that you have finally got caught and, you know, they
19 have got all sorts of things they are going to do to
20 you, or they might do to you, they might not, it seems
21 almost serio-comic because, you know, on the one hand
22 they just busted you and on the other hand they are
23 saying, "Don't worry about, you know, just lay off and
24 quit". And so you go into the police station and you
25 sit around, you know, it happens that you sit in a
26 room where they come and they book all sorts of people,
27 and when I was in there they booked three people, chronic
28 alcoholics, every one of them. One chap was forty-eight
29 years old and I swore --- I would have sworn he was
30 seventy. He has been in and out of that place they say

1 they see him every five weeks, he spends four weeks in
2 jail, he is out a week and he's back. And during the
3 whole while the policemen were having conversations
4 about big parties and it seemed they really had a
5 predilection for alcohol and I sat and I listened to
6 it all and, you know, it was fine, and then they thought,
7 "well, who is this kid, he's sitting there with school
8 books in his hand, no blood on his face, looks scared
9 out of his mind, what's he up here for?" So they look
10 and they see marijuana. Well you know, they are all
11 shocked. A son of the middle classes has somehow
12 rejected all of their values, and they start telling me
13 to watch out or I'll become a junkie just like the rest
14 of them and things like this. They just can't help
15 but alienate you from the whole system. It seems
16 almost just like instant--before this you could say
17 change will come, things will happen, you don't have to
18 worry about it too much. They are responsible people
19 who are going to look after the interests of the people,
20 the sort of subculture that exists which is so wide
21 spread now. The thing is you are suddenly so shocked
22 because there is authority that still has this power and
23 the cops are sitting there and telling me that marijuana
24 is addictive and they have the power to do something to
25 me or to anyone of us in this room, and I don't see the
26 right of them having this power. I don't care, you know,
27 so I have a criminal record now, I'm not going to let it
28 bother me too much. I will do what I can. It is a
29 serious damper on a lot of things I could do--I can't go
30 into law now and things like that. It just seems to me

1 that the whole thing of authority is out of touch with
2 what is really happening with the people. I mean when
3 the policemen think things like this and it is their
4 job, then what kind of position are we in? It scares
5 me anyway, you know. And as a result I have had to
6 change my whole life style because of this happening.
7 I can't associate with the same people that I did before
8 and I can't do the same sort of things I did before. I
9 can't use marijuana, for the simple fact that if it was
10 to happen again, this time I would go to jail for
11 something that is only related to what I do with myself.

12 THE CHAIRMAN: The lady--could
13 you use the microphone?

14 THE PUBLIC: It seems to me that
15 there is a little bit of contradiction because if you
16 are thinking of values and so on, and tranquillizers
17 as perhaps being inadequate, and this fellow over here
18 says marijuana may be a tranquillizer. And I thought
19 at the time that he was sort of implying that it
20 should be on the same level as the tranquillizers.
21 And then he started speaking of discontent. Now if
22 someone is discontented, should he take a tranquillizer
23 so that he forgets about it, and therefore doesn't
24 achieve any social change? I am interested in the
25 idea of the legalization of marijuana, and I am
26 wondering if it couldn't be a welcome use against--
27 maybe this is a word that is overused--but by the
28 establishment because if you do--if you are just
29 tied into the system, they say you can have your
30 marijuana and it is okay, and they don't accomplish

1 any social change, and then does the Board really want
2 young people to accomplish social change? We were
3 talking about viable alternatives, what would happen
4 if the people were to decide that they don't like the
5 things as they are and they really wanted radical
6 change. These are just a few of the ideas that I
7 have, and I do see a contradiction too. I am not
8 taking a position on anything here, this is just a
9 few of the ideas, and you have to decide what you
10 really want young people to do.

11 THE CHAIRMAN: Thank you.

12 THE PUBLIC: Just as a
13 partial reply, I think she is a little bit off base
14 when she says that people who are smoking marijuana
15 sort of retreat, and try not to effect any sort of
16 social change or forget about social change, because
17 I think a lot of the people who are into marijuana,
18 who are using marijuana, I think you will find a lot
19 of them would be in the groups that are coming up
20 to-day, that are in some people's eyes very, very
21 radical, and are in some ways the pushing factor, the
22 motive behind a lot of the social change which is
23 taking place in our society today. And I doubt
24 very much if it can be just generally said that
25 smoking marijuana would sort of make you complacent,
26 just tie you into the womb of the establishment; you
27 would be happy there. Because that is just not what
28 is happening.

29 THE CHAIRMAN: I think we
30 should release Dr. Cameron and Dr. Anderson. Thank

1 you very much for your assistance, and I am sure that
2 you are very busy and we have kept you quite long. We
3 are very obliged.

4 I didn't want to
5 interrupt your discussion from the floor, but I would
6 just call now on the Pharmaceutical Manufacturers
7 Association of Canada, represented today by Dr.
8 William Wigle, President, Mr. J. Donald Harper, Director
9 of Public Relations, Mr. V. H. Hakes, Chairman of
10 Drug Abuse Committee, and Dr. A. Moriarity, Medical
11 Director of Smith, Kline & French, Canada, and Mr.
12 F. R. Hume, Legal Counsel.

13 THE PUBLIC: In last night's
14 Spectator there was a bit on one page that they are
15 going to supply twenty people with marijuana to smoke
16 heavily for three months. How do you feel about it,
17 and where can I join it?

18 THE CHAIRMAN: I assume that
19 that is in reference to the Research Project of the
20 Addiction Research Foundation of Ontario. But of
21 course as a Commission of Inquiry, we are very
22 interested in the research that is going to be carried
23 out in Canada and the United States within the next
24 year and we hope that we can get useful information
25 from it for the purposes of this Inquiry.

26 Yes?

27 THE PUBLIC: I was just
28 wondering whether anybody on the Inquiry had taken
29 marijuana. I am sure you have had the opportunity,
30 but have you ever tried it? Maybe it is a personal

1 question, I shouldn't ask you but if you haven't, I
2 think it is a terrible thing, because I can remember
3 before I knew anything about it, just knowing what I
4 had read and it really sounded like something
5 fantastic and all this talk and all this concern,
6 and all these worries and all these laws and all these
7 people going to jail, and then when I did find out
8 about it, it's a nice little thing but nothing to
9 get upset about. Nothing to be really worried about.
10 Alcohol takes away much more control. Like that person
11 said yesterday, if you could go out to a nice peaceful
12 lake and lay on your back and look at the sun and
13 the trees, you are almost there. And marijuana just
14 does not have that much effect. It is nice. And all
15 this concern, I just don't understand it. I can
16 understand it for heroin, for alcohol, for the
17 amphetamines, for LSD; but marijuana, it is nothing
18 to get concerned about. It is nice but all this
19 talk and all this worry, it just isn't up to it. And
20 I think if you tried it and knew what it was about,
21 you would realize what you are talking about it. It
22 is like being afraid of the dark. You are afraid of
23 something you don't understand, but once you understand
24 it, it is just a nice little thing and not worth
25 getting worried about. And certainly the laws, this
26 is the problem. Having it illegal, all of these
27 people are worried about it. All these people are
28 trying it and getting involved in it, and if it
29 wasn't built up so big, and if people really tried
30 it, there would not be anything. It's nice but it's

1 nothing to get worried about. And that is for sure.

2 One more thing, that lady
3 over there who said she wondered if there was any
4 harmful effects with it --- ma'am you wondered if
5 there were harmful effects with marijuana. Well there
6 is. It is not strong enough to do anything by itself,
7 but if you are --- if your mind is all balled up
8 already and like, I know a girl who is crazy already
9 and when she takes marijuana she's up and down. She
10 gets more depressed than if she wasn't taking anything
11 and higher than if she wasn't taking anything, but
12 not to the degree that it really changes her. By
13 itself it just magnifies it. She can relax and just
14 think about her problems, which she probably wouldn't
15 do if she was ^{not} on marijuana. But by itself --- it is
16 not much by itself. Hash and that is a bit stronger
17 but really the whole thing isn't all that great. I
18 just wish more people would get into it and try it,
19 because if everybody had tried it, if everybody took
20 ten drugs every day, then everybody would say, "Oh, it's
21 nothing, let's go on to something more important."
22 There are more things that are important. Our society,
23 this plastic, concrete, asphalt, unnatural, unreal
24 world that we have created for the human species. That
25 is more important than all this trash about marijuana.
26 It is such a small thing compared to the really
27 important things we have got to change, and I think
28 we should put it out of our mind because it is really
29 nothing. And you have got to worry about your kid,
30 what he loves and what he hates, not something like

1 marijuana, really. I am just sorry that everybody is
2 so concerned about it, because there are more things
3 to be concerned about.

4 THE CHAIRMAN: Well I just
5 would observe that our terms of reference require
6 that we look at all types of drugs, and multiple drug
7 use and we are not just looking at marijuana.

8 THE PUBLIC: Could I just
9 ask this gentleman a question, are you speaking as a
10 twenty-year user?

11 THE CHAIRMAN: We call on
12 Dr. Wigle, President of the Pharmaceutical Manufacturers
13 Association. Would you introduce your colleagues please?

14 DR. WIGLE: Thank you, Mr
15 Chairman, I must say as a physician and a father that
16 I could probably just enjoy more sitting back there
17 for the rest of the day, and listening to the
18 presentations that are being made. I thought the
19 doctors this morning expressed themselves very well. I
20 think you have a fascinating chore. Our delegation
21 whom you mentioned previously, just for individual
22 identification, I would like to identify Mr. Fred Hume,
23 our legal counsel, on the extreme left nearest you; and
24 Mr. Hakes, president of Eli Lilly of Canada, one of the
25 largest producers of barbiturates; and Dr. Moriarity,
26 one of the Directors of Smith, Kline & French in Canada,
27 and Smith, Kline & French are one of the large producers
28 of amphetamines; and on my right Mr. J. D. Harper, our
29 Director of Public Relations in the PMAC. As you will
30 see, on the Committee that we used to develop our

1 presentation to you, we tried to involve companies
2 that were immediately concerned with some of those
3 products with which you are concerned and remarking
4 on them in Canada. You just received our brief
5 this morning, I realize that, and it is some twelve
6 pages. I would take your direction as to whether you
7 would like me to read it, and it would take us about
8 fifteen or twenty minutes.

9 THE CHAIRMAN: Yes. I think
10 think that would be best.

11 DR. WIGLE: Well then if that
12 is your wish, we could start off at the introduction
13 in which we will just draw to your attention that
14 our Association is a voluntary non-profit scientific
15 and trade association composed of fifty-eight
16 research-based companies engaged in the development,
17 production and distribution of prescription medicines
18 and we welcome the opportunity to present our views
19 on the non-medical use of drugs.

20 Reputable manufacturers of
21 prescription medicines, as represented by PMAC, share
22 with you a deep concern about drug misuse.

23 Research conducted by our
24 member companies have resulted in medicinal products
25 which have brought immeasurable benefits to society.
26 These benefits are experienced every day by patients
27 who use these products properly as their physicians
28 prescribe them. It is unfortunate that very few of
29 the medicines are being misused for non-medical
30 purposes.

As a result of the amount of research and the years of experience by our member companies in the effects of medicinal substances on the human body, we feel it is part of our obligation to society to make available any observations which might be helpful to the Commission and to explain the role of our members and other legitimate pharmaceutical manufacturers.

One of the basic obligations any pharmaceutical manufacturer has is to effectively control his manufacturing operations and his distribution system in order to prevent leakage of his products from the legitimate channels of distribution into illicit channels. It should be pointed out that whatever action is taken to control production and distribution of pharmaceuticals by legitimate companies, it will have no effect on the illegal sale of unlicensed products manufactured by or procured from non-legitimate or illicit sources.

In the long history of this Association, our member companies have assisted the Narcotic and Controlled Drug Division of the Food and Drug Directorate in their activities. Reputable manufacturers of prescription medications have no part to play in illegal drug production and so pledge themselves.

Criticism: criticism has been levelled from different quarters at the pharmaceutical industry for overselling, overproduction and improper control of the the distribution of certain drugs,

including barbiturates and amphetamines. We believe this criticism comes from press reports of conditions in other countries. We would like to point out to the Commission that in Canada the production and distribution of preparations of this type are treated as Controlled Drugs. While it is possible to manufacture an unlimited quantity of such products, it is not possible for the manufacturer to sell them other than to licensed dealers. Therefore, the demand created in the system through physicians' prescriptions indirectly regulates the quantity that will be legitimately manufactured or the inventory that will be carried.

Manufacturers acquaint doctors with their products' legitimate medical uses through various means, but one which readily lends itself to scrutiny is the advertisement in the medical journal. The lack of marketing emphasis on barbiturates and amphetamines is underlined by an examination of the prominent Canadian medical journals, published between December 1969 and April 1970. During this period when some 1,445 pharmaceutical ads were carried, only 3.0% were for barbiturate-containing products and only 0.5% were for amphetamine-containing products. We have set a table up in Appendix form.

Legitimate consumption of amphetamines and barbiturates for manufacture in our industry is not increasing; 1969 consumption of amphetamines is 24% below the peak year of 1966 and 1969 barbiturate consumption is 14% below the peak

1 year of 1965.

2 And we have another appended
3 table which gives you those facts.

4 Regulations to prevent "Leakage" into illicit channels;

5 In fact, the present Controlled
6 Drug Regulations governing the purchase and sale of
7 barbiturates and amphetamines were established with
8 the willing co-operation and assistance of Canada
9 pharmaceutical manufacturers.

10 Are these regulations adequate
11 to do the job? To answer this, we will briefly
12 summarize their effect during the life history of a
13 controlled drug medication. Attached in Appendix "C"
14 is a copy of the complete text of the Food and Drug
15 Regulations Schedule G upon which this summary is based.

16 If I might pause there, Mr.
17 Chairman, the presentation of this Schedule G, at first
18 some of our members thought it might be presumptuous
19 of us to append this section of the Food and Drugs Act,
20 but we had reason to believe that perhaps your Commission
21 had not yet been exposed to that Schedule and so we
22 have included it here for your identification.

23 THE CHAIRMAN: We know of
24 it but we find it very convenient to have it at the
25 back of your brief.

26 DR. WIGLE: Continuing
27 discussions between manufacturers and Controlled Drug
28 officials indicate that the federal officials are not
29 having any problems with legitimately produced drugs
30 being diverted to illicit traffic. They can attest that

1 amphetamines and barbiturates in this illicit traffic
2 are not coming from medical supply but from clandestine
3 sources.

4 Indeed, it would seem to us
5 that testimony by the knowledgeable and competent
6 officials of the Narcotic and Controlled Drug Division
7 of the Food and Drug Directorate would be useful to
8 this Commission. And that is one of our suggestions.

9 The Life History of a Controlled Drug;

10 Barbiturates and amphetamines
11 are Controlled Drugs in Canada. Therefore, they cannot
12 be advertised to the general public.

13 Advertisements to the medical
14 profession must carry the symbol which you see printed
15 here "in a clear and conspicuous colour and size in
16 the upper left quarter of the first page of the ad."
17 And those are the advertisements to the medical
18 profession.

19 No person in Canada can manu-
20 facture, import, export or sell a controlled drug
21 unless he has been licensed as a dealer by the
22 Department of National Health and Welfare. The license
23 does not apply to all controlled drugs, but specifies
the patent
24 the particular ones that/dealer may sell. These
25 licenses can be suspended or revoked if a dealer fails
26 to comply with any terms or conditions of the license.

27 The manufacturer obtains his
28 raw material controlled drugs from a licensed supplier.
29 Both supplier and manufacturer must record how much
30 raw material they received, who they received it from,

1 where it came from and when it was received. They
2 must record the same information for any controlled
3 drug which they supply to others.

4 When the raw materials are
5 formulated into a product by the manufacturer, records
6 must be kept of the amounts used, what products it
7 went into, how much was produced, the dates, as well
8 as keeping a monthly inventory of raw materials,
9 in process and finished products which must be
10 reconciled.

11 The Minister of Health's
12 Narcotic and Controlled Drug officials inspect the
13 premises, processes, qualifications, records and
14 inventory regularly to ensure that no improper
15 activities take place. These records are kept for
16 two years in a form facilitating auditing.

17 The manufacturer is required
18 to store controlled drugs to provide protection
19 against loss or theft, must seal containers of controlled
20 drugs so they cannot be opened without breaking the seal,
21 he must ensure the safekeeping of controlled drugs
22 during transit by using methods of transportation which
23 keep an accurate record of the drug and signatures of
24 persons having charge of the drug until it is delivered
25 to the licensed consignee. The original order from
26 purchasers must be verified.

27 The hospital pharmacist,
28 medical practitioner, etc. who has been licensed to
29 purchase controlled drugs must record what was received,
30 who the supplier was, the use to which it was put ---

1 and must make these records available for regular
2 inspection and reconciling.

3 Voluntary Controls;

4 Our members are working under
5 these regulations and recognize that it is probably
6 impossible for government to legislate against every
7 conceivable loophole. In the course of our
8 continuing liaison with the competent officials of
9 the Controlled Drug Division of the Food and Drug
10 Directorate, we have become aware of the need for each
11 manufacturer to pledge himself voluntarily to
12 additional self-imposed controls.

13 One possible area of abuse
14 is in the sales of empty gelatin capsules, as empt-
15 capsules can be used to provide a convenient dosage form
16 for illicit substances which are distributed through
17 underground channels. Therefore, manufacturers and
18 distributors of empty gelatin capsules have an
19 obligation to assure themselves of the legitimate
20 purposes for which their empty capsules will be sold.

21 Another area of potential abuse
22 which has been mentioned by some observers is the sample
23 material distributed to physicians and, in some
24 instances, to paramedical personnel. As a result, and
25 after considerable examination of the situation, our
26 industry has proposed to the Minister of National Health
27 and Welfare in March 1970 that the Food and Drugs Act
28 and Regulations thereunder be amended to forbid the
29 distribution of unsolicited samples of all pharmaceutical
30 products. This is already being followed as a matter

1 of company policy by several member companies. If
2 adopted, it can be assured that no longer will
3 samples of medication be distributed in Canada other
4 than on the specific written request of an authorized
5 individual who would request the sample for a
6 legitimate purpose.

7 Further on our responsibilities,
8 among the Principles of Ethics subscribed to by every
9 member of PMAC are these:

10 The pharmaceutical manufacturer must produce his
11 preparations only under proper conditions and with
12 scrupulous faithfulness to required standards of
13 quality, and
14 Preparations must be labelled and merchandised only
15 in a manner free of misrepresentation, misleading
16 practices of all kinds and in entire harmony with the
17 highest standards of commercial morality and professional
18 ethics.

19 This provides society with the
20 assurance that the manufacturer's systems are designed
21 to provide proper personnel, product design, specifica-
22 tions and procedures, facilities and equipment, materials,
23 security and records. Provision has been made for
24 the audit, evaluation, maintenance and revision of
25 these systems.

26 The key element by which
27 administrative control of each lot of product is
28 maintained is the lot numbering system and related
29 documentation. This is a system of identifying each
30 product lot and includes marking of each distributed

1 package so that the manufacturer can establish the
2 history of the package and its contents, the source of
3 each ingredient, the records of tests on each ingredient
4 and on the final product, the identity of the
5 individuals responsible for each of the steps in the
6 manufacturing process and the individual who checked each
7 key step. Such lot number also relates to records of
8 the packaging operations and the final audit for the
9 total number of packages produced.

10 Manufacturers have a moral and
11 corporate responsibility to do what they can to assure
12 that their products stay in lawful channels. Great effort
13 must be devoted to the selection of reputable and
14 ethical customers.

15 Security of the manufacturing
16 and distribution system must be a prime concern, not
17 just for controlled drugs but for all pharmaceuticals,
18 especially those with marked effect on the mind.
19 Parcels and packages need to be subject to inspection
20 as employees leave the plant. Visitors require
21 careful screening and should be identified and
22 escorted while on the premises.

23 Purchases of controlled drugs
24 should be monitored and customers asked to explain any
25 unusual departures from the norm. Stringent voluntary
26 and mandatory controls over manufacturing and
27 distribution operations prevent diversion and
28 pilferage. Raw materials, in process and finished
29 pharmaceuticals should be given every protection
30 possible.

1 In the introduction, we
2 commented on the research base of our industry. Our
3 expertise deals with the effects of medicinal
4 substances on the human body.

5 We have made mention of the
6 fact that all too little scientific research on the
7 action and effect of non-medical drugs on the human
8 body has been conducted. We propose that a meeting
9 of representatives from this Commissions's Research
10 Staff, the Controlled Drug Division of the Department
11 of National Health and Welfare and PMAC's Medical
12 section which comprises some fifty physicians engaged
13 full time on drug-related matters in our industry,
14 that such a conference be held for the specific
15 purposes of revealing needed scientific research
16 projects which would provide needed information on such
17 non-medicinal substances as marijuana, LSD, etc.
18 It would be information that would be of assistance in
19 the study of Drug Abuse. From these may well emerge
20 projects which PMAC might aid in funding, which could
21 be deemed appropriate as part of our contribution to
22 solving this pressing problem.

23 It may be that some of
24 these research projects could be carried out through
25 the Canadian Foundation for the Advancement of
26 Therapeutics, an organization founded by PMAC to encourage
27 the development of clinical pharmacology as a
28 specialty in Canada.

29 In addition, as the Canadian
30 member of the International Federation of Pharmaceutical

1 Manufacturers Associations, we have access to information
2 from multi-national research sources including the
3 Phrrmaceutical Manufacturers Associations of the United
4 States and the United Kingdom. We would like to put
5 at the disposal of this Commission, and any other
6 Federal Government researcher, our ability to tap
7 the resources of a unique Science Information Service
8 made available through the U.S. Pharmaceutical
9 Manufacturers Association. This service allows
10 analysts to search the computerized version of Index
11 Medicus. It is called Medlars. It contains some one
12 million articles that have appeared in 2,300 bio-medical
13 journals published throughout the world since 1954.
14 Approximately 20,000 new articles are indexed each
15 month and stored on computer tape and these are
16 available for routine searches retrospectively for any
17 area of interest that might have bearing on the drug
18 abuse problem. PMAC would be happy to make its
19 facilities available for access by the government to
20 this unique Medlars computer facility.

21 Support of Educational Programmes;

22 In addition, we will continue
23 participating in events such as the International
24 Conference on Drug Abuse held in New York City on
25 June 2, 1969, attending the United Nations Narcotic
26 Commission discussions on Dependence-Producing
27 Psychotropic Substances in Geneva. That was my
28 personal privilege, sir, to sit for the final week of
29 deliberations of the United Nations Narcotic Commission
30 dealing with the development of a protocol that hopefully would be

1 adopted internationally for the control of psychotropic
2 producing substances, and I have expressed in writing
3 to the Canadian Medical Association journal recently
4 the hope that perhaps the findings of your Commission
5 might be available before the world makes up its mind
6 about that final protocol.

7 THE CHAIRMAN: We are aware
8 of the protocol and we hope that the date of the
9 session in the spring of '71 can be so fixed
10 as to permit us to get out our final report.

11 DR. WIGLE: I am sure Dr.
12 Chapman has expressed his concern to you.

13 And we have underwritten costs
14 of publishing the minutes of the Canadian Higher
15 Education Conference titled "Drugs, Student Use and
16 Abuse", a professional programme of the Canadian
17 Student Affairs Association, held at the beginning
18 of November, 1968 at Loyola University of Montreal,
19 underwriting costs of publishing the text of the St.
20 Francis Xavier University, Antigonish, N.S. Symposium
21 on Non-Medical Use of Drugs, February 17, 18, 1970
22 and such other activities as seem appropriate in helping
23 chart a course that will lead society out of this
24 problem.

25 Most young people are getting
26 their information about drugs from newspapers, from
27 students, or friends or other sources and much of this
28 information is inaccurate and misleading. PMAC feels
29 it is essential for national coordination to be
30 established in coping with drug abuse educational

1 activities. We are eager and willing to participate
2 and co-operate in such an effort.

3 Many programmes dealing with
4 drug abuse have sprung up across the country sponsored
5 by well-meaning public-spirited groups of citizens.
6 Because of the multiplicity of the many regional and
7 local activities, we are more or less precluded from
8 making any major contribution to these individually.
9 Our major support can be through the provision of
10 resource material such as our booklets, reading and
11 film lists which we keep complete and up to date,
12 copies of speeches, and so on. This will assist these
13 local groups greatly in providing more factual up-to-
14 date material at the local level at which they are
15 best equipped to operate. Mr. Chairman, I wouldn't want
16 you to misunderstand that PMAC feels the drug problem
17 as expressed to you this morning is the problem. We,
18 as individuals, of course, feel it is a symptom but we
19 do not feel that is within the prerogative of the
20 presentation of the Manufacturers Association.

21 We feel that one of the
22 pressing needs is to provide society with a heightened
23 awareness and respect for the potency of the various
24 things which they put into their bodies. Our industry has
25 a responsibility to provide materials about the proper
26 use of medicines to assist in re-establishing respect
27 for medicines as products to be used according to
28 directions only. To this end, our industry is
29 distributing widely a new booklet, "The Medicines Your
30 Doctor Prescribes" as a guide for consumers, reminding

1 them that modern medicines can help to keep you well or
2 restore you to good health with more certainty, more
3 safety, and more actual economy than ever before, provided
4 you know the facts about them and use them wisely, and
5 only when necessary. This pamphlet which we have
6 included here does not speak directly on drug abuse, but
7 it does provide information which we hope will guard
8 against future unintentional abuse of medicines and
9 it is, therefore, useful in a long-range educational
10 effort. It is being made available through physicians'
11 offices, pharmacies, Reader's Digest ads, school health and
12 guidance teachers, and drug abuse organizations.

13 We are prepared to distribute
14 to anyone who contacts us, or that we can reach, copies
15 of the attached kit designed to put in the hands of
16 people working on the drug abuse problem appropriate
17 materials to assist them in their task. And that brief,
18 sir, I believe is included with each of the copies of
19 the brief you have to-day. We think the materials are
20 appropriate to assist them in their task.

21 It is also our Association's
22 policy to endorse the work of bona fide province-wide
23 or nation-wide programmes dealing constructively and
24 effectively with the problems of drug abuse and misuse.
25 After studying the problem, our Board of Directors feels
26 that it is important to recognize the desirability of
27 national coordination in the activities of the various
28 groups to obtain maximum impact and benefit from the
29 resources allocated to coping with this social problem.
30 Our individual member companies are participating in the work

1 of many of the local and national groups within their
2 own capability and discretion. For example, the Council
3 on Drug Abuse, a pharmaceutical industry project, and
4 the Quebec College of Pharmacists, whose activities you are
5 aware of, I am sure. Our member companies are prominent
6 in the financial and active support of these organizations
7 and many others, and this work is to be highly commended
8 since it will attempt to prepare films, television spots,
9 radio spots, and other educational material which will
10 portray the truth about abusive use of chemicals and
11 other substances.

12 We are, as we said, maintain-
13 ing international liaison with other organizations
14 through the IFPMA and the associations similar to
15 ourselves in other countries of the world and we hope
16 that we can get material that might be useful from them
17 as well. One that we are aware of is the joint effort
18 between the Pharmaceutical Manufacturers Association in
19 the United States and the American School Health Asso-
20 ciation, where they will be jointly producing a model
21 curriculum guide for school use in grades kindergarten
22 through grade XII to teach about the proper and improper
23 use of drugs. And this, I believe, is not just a
24 programme condemning marijuana or any other substances,
25 but is aimed at people having a better understanding
26 of, as we put it, the chemicals they put into their
27 bodies. This national curriculum guide will likely
28 have more real value than many a more flamboyant effort,
29 and we will be keeping close contact with this develop-
30 ment so that any potential benefits from it might be

made available in Canada as well.

Let me close by saying our association will actively pursue these efforts as well as any others that seem important and needed resources in the hands of those people who can administer them effectively in dealing with today's youthful abusers.

I am not just sure that in the rewriting we might not have taken out that word 'youthful'. It is not meant to be in any way a condemnation. I think with those words, Mr. Chairman, I would like to re-emphasize the fact that we have tried to confine ourselves to those areas appropriate to the Manufacturers Association although we are deeply concerned with the total essential problem which is in your hands most of the time.

THE CHAIRMAN: Thank you, Dr. Wigle. I wonder if any of your colleagues would care to add any statement?

DR. WIGLE: I am sure that any one of them would be pleased to answer any questions. As I mentioned, Mr. Hume is our legal counsel Mr. Hakes is from the Eli Lilly Company which is the manufacturer of barbiturates; Dr. Moriarity is very knowledgeable in the area of amphetamines, and Don Harper is the boy who has been familiar with the total programme across Canada on behalf of our association and with preparation of the actual wording.

MR. STEIN: I wonder if perhaps you could indicate whether or not you have

1 concern about the industry's distribution of the minor
2 tranquillizers. I notice that you made reference to
3 the self-controlling regular type procedures that are
4 presently available in relation to barbiturates and
5 amphetamines, but there was no reference at all to the
6 minor tranquillizers. Have you left them out for some
7 particular reason?

8 DR. WIGLE: Could you state
9 to the location of that in the Control?

10 MR. HARPER: We have not
11 included the minor tranquillizers in the brief directly
12 because they are not controlled substances. They are
13 Schedule F drugs and require a prescription. They do
14 not need the same amount of controlability, or accountability
15 needed to document everything, as extensively as the
16 amphetamines and barbiturates.

17 THE CHAIRMAN: But they do
18 call presumably for control and you have a section here
19 --- excuse me --- I just wanted to see if this was
20 correct here. We have assumed, we draw the conclusion
21 that the minor tranquillizers have replaced to a
22 considerable extent the barbiturates, and they account
23 in part for the increased use of tranquillizers and
24 may in time account in part for the decreased use of
25 barbiturates.

26 MR. HARPER: Our brief deals
27 with barbiturates and amphetamines because these are
28 the substances that were mostly discussed as abused
29 substances beyond medical use. However, we were anxious
30 to get direction from your thinking at this point whether

1 we should be looking at the minor tranquillizers,
2 internally. We are willing to voluntarily control them
3 as we do all of our drugs. Maybe some additional
4 control is warranted. But we did not feel at this point
5 we were able to make any recommendations until we
6 learned some feed-back from your Commission.

7 MR. STEIN: Actually my
8 question was really directed in that sense to the
9 industry's concern, whether there was in fact a concern
10 for more effective control of minor tranquillizers.

11 DR. WIGLE: There is a great
12 concern, Mr. Chairman, and this is very evident in the
13 assistance which the industry has given to the develop-
14 ment of the Protocol in Geneva and all of those minor
15 tranquillizers are included in that protocol as one of
16 the sections of psychotropic substances. And as far as
17 the use of them instead of phenobarbital etc. is con-
18 cerned, I think this is a very mute point. I was speaking
19 with three pharmacologists last week in which I said,
20 "Why do we, as physicians, always feel that we are so
21 morally superior, if we have gone back to phenobarb
22 instead of using one of the modern tranquillizers"? He
23 said, "I don't know, it's some kind of a thing we have
24 about something new". Actually he felt as a practicing
25 clinical pharmacologist that these things would replace
26 eventually the barbiturates but that was for side informati

27 THE CHAIRMAN: I suppose a
28 general question which we are very much interested in is
29 the relationship between the productive--the production
30 and the supply and the licensed outlets in their

1 responsibility if any, for increased consumption. You
2 dealt with this, you referred to the extended advertising
3 and the impression I draw from the brief is that you
4 feel that the increased consumption of drugs cannot
5 contribute to lack of control and the amount of
6 production. It is stimulated, apart from the user's own
7 motivation it is stimulated to a degree by doctor's
8 prescriptions and I suppose pharmacists would also be
9 involved.

10 DR. WIGLE: All of these
11 products are on prescription.

12 THE CHAIRMAN: They are all
13 on prescription? So that-it is very important for us
14 to really satisfy ourselves on what is the responsibility
15 if any, on the production level --- what can be done,
16 what influences the amount of production we have or
17 consumption. You do advertise --- you estimate that
18 if you had produced, you are stuck with production and
19 like any manufacturer who is in the business for profit,
20 you get rid of your wares, and the estimate --- the
21 consumption question cannot be so nicely adjusted. You
22 just follow behind it. You must make estimates on it,
23 you are stuck with it, you have inventory.

24 DR. WIGLE: Perhaps Mr.
25 Hakes would like to speak on that.

26 MR. HAKES: First, I would
27 like to say that you hear about say, librium and drugs of
28 this kind, and amphetamine; there are many of course
29 that never reach this popularity. I think in my
30 experience a drug reaches its expended use, increased

1 use because it does a job and because physicians find
2 it useful too in their practice. And so the drug that
3 does not fall into lead, falls by the wayside and is
4 discontinued. I don't think in general there is any
5 way with over-production causing use because we are
6 held so tightly to accountability for the product ---
7 in the controlled drug area.

8 We feel that in promotion ---
9 if you can call it promotion --- that we have an
10 obligation to acquaint physicians with the use of a
11 product, and so this is really where we can find our
12 contact, advertising to acquaint the physician with the
13 use and counter education of some drugs. This does,
14 of course, extend the use as they become better acquainted
15 with it. I don't feel as a person engaged in the
16 industry, how over-production could possibly cause
17 misuse. I think it could in other countries where it
18 isn't as tightly controlled. I don't know whether that
19 answers your question.

20 THE CHAIRMAN: When you are
21 speaking of that, you mean to prevent leakage into
22 illicit channels?

23 MR. HAKES: Yes, sir.

24 THE CHAIRMAN: One of the
25 things I was interested in, Mr. Hakes, on Page 4, sub-
26 paragraph 3 "to aversion of amphetamines and
27 barbiturates" and to illicit traffic, the implication
28 being that there is some clandestine source for bar-
29 biturates. We are not aware of any evidence of that.
30 Amphetamines is another thing that we are not aware of

1 any clandestine source --- I may be corrected by the
2 staff but my recollection is we do not have evidence
3 of clandestine source of barbiturates.

4 DR. WIGLE: The statement
5 that was here was based on the discussions with the
6 people in the Narcotic Control and Controlled Drug
7 area who said that they had no evidence that the abused
8 barbiturates found on the streets etc. and the amphetamines
9 came from legal channels, but Mr. Harper may want to
10 supplement that.

11 MR. HARPER: There would be
12 ones, in our continuing liaison with them as we have had
13 ever since we assisted them in establishing the Controlled
14 Drug regulations, there would be ones that indicated
15 to us that they are not finding our products in illicit
16 traffic unless they have been illegally stolen by
17 someone raiding a drug store, and taking the products,
18 that much of the material that they find in illicit
19 traffic is from illicit underground laboratories.
20 And I have seen some press references to this, and I
21 am sorry I don't have them with me. That is one of
22 the reasons we suggested maybe testimony by them would
23 be appropriate.

24 THE CHAIRMAN: Well, we have
25 invited ---

26 DR. WIGLE: Or smuggled it
27 into the country.

28 THE CHAIRMAN: I just want
29 to make as a matter of record and I don't know what
30 your information has been, but we have asked the

1 Narcotics Division to testify and we have a letter on
2 file to the effect they choose not to testify, but in
3 fact --- they didn't see that was necessary at the
4 time --- but in fact our staff are in very close
5 contact with them as you would expect. But I gather
6 the staff is rather adamant on this point, that there
7 is no evidence of clandestine source of barbiturates.
8 That may have been an inference that you or anyone might
9 draw from their statement that they have no evidence
10 of diversion of barbiturates from legitimate sources.
11 And I just have another note passed to me, that the
12 R.C.M.P. testimony is to the effect --- before us, is
13 to the effect that all barbiturates come from legitimate
14 sources, so we have a point that requires, I think, a
15 little more investigation by us as well. I mean I
16 think we will have to confirm our assumption here.

17 DR. WIGLE: They might have
18 originated from a legitimate source, but somehow they
19 fell into illegitimate hands.

20 MR. HARPER: By being stolen
21 or something.

22 THE CHAIRMAN: In other words
23 the R.C.M.P. are saying the same, something to the
24 same effect, that they know of no clandestine sources
25 of barbiturates, however, we will find that out to
26 the best of our ability.

27 DR. WIGLE: We don't know
28 of any clandestine sources either.

29 THE CHAIRMAN: That was
30 an inference drawn-- of diversion. Yes.

1 MR. STEIN: On the question of
2 advertising, does the industry have any views regarding
3 the appropriateness of advertising for those drugs
4 which are not prescription drugs, over the counter drugs,
5 in other words, the non-controlled drugs?

6 DR. WIGLE: There is another
7 association in Canada called the Proprietary Association
8 of Canada which sells most of those products which are
9 over the counter, and we try to stay out of their
10 field of activities, because they operate under a
11 different Act, the Patent and Trade---

12 MR. STEIN: Just let me---

13 DR. WIGLE: The Patent Medicines
14 Act.

15 MR. STEIN: I don't mean to
16 play dirty-pool but I will address you as a father, you,
17 at one point during the morning were in that role.

18 THE CHAIRMAN: But not at table.

19 MR. STEIN: That's quite correct
20 and you can reject my question. But I wondered if the
21 industry had--in other words, let me put it this way:
22 many people have views on the law and they are not expert
23 lawyers; many people have expressed views to us on the
24 appropriateness or the inappropriateness of the medical
25 response to this phenomenon and they are not only doctors.
26 So I appreciate your reservations in commenting on another
27 area, but I wonder if you can, frankly if you can avoid
28 having some observations on that aspect of what is a very
29 related phenomenon, namely the over the counter advertising.

30 DR. WIGLE: I just wish you

1 would ask some other father because I put my whole
2 job in jeopardy, but I will answer your question
3 frankly, and not as the President of PMAC. I am
4 embarrassed as a physician by some of the type of
5 advertising of over the counter things that is fed
6 to us by television and through television and soon.
7 And as an individual I believe that part of the
8 problem in society is the creation of the belief that
9 there is something that you take for everything. Now
10 I may be getting myself into deep water, my colleagues
11 will be kicking me under the table, but I seriously
12 feel, as an individual, and that's the way I will
13 speak to you, if we have a problem in society, part
14 of it is that. But I am not too sure that it is
15 simpler to persuade the husband to shoot the dog and
16 then have to deal with how he gets along with himself,
17 because the dog is the problem with the wife and she
18 doesn't like the dog in the house, you see. And you
19 persuade him to shoot the dog to solve the problem
20 and then he has got the problem, or would you give the
21 wife something and let her live with the dog. You know,
22 which is worse in society? So as a father, I think it
23 is unfortunate, in relation to this advertising, that we
24 do tend to create the impression that "Gee, dad, I
25 have got a pain in my big toe, what are you going to
26 give me for it?"

27 MR. CAMPBELL: I think there
28 are, however, drugs that are manufactured by the com-
29 panies in your association that are sold over the
30 counter without prescription and are subject to rather

1 dangerous use. For instance, 222's are not infrequently
2 used by young people in, say, lots of 20 to 25 at a
3 time for their codeine content. Do you feel there
4 are adequate controls on the distribution of drugs such
5 as 222's?

6 DR. WIGLE: Again, I haven't
7 got an opinion on behalf of the Association on this,
8 but I think that anything for which there is proof
9 of abuse, there should somehow or other be better
10 methods of control.

11 MR. CAMPBELL: You used the
12 word "abuse", in well, that last sentence, and you also
13 use it in your brief. What is the view of the association
14 on the nature of drug abuse; what is the difference
15 between drug use and drug abuse?

16 DR. WIGLE: I think I
17 would bow to the description that the doctor gave you
18 here this morning, and I can't remember the exact
19 wording, but it was something of the effect that when
20 the chemical that was ingested became a problem rather
21 than a cure. I can't remember, but I think the doctor
22 here this morning had an excellent definition and I
23 would agree with that definition.

24 MR. CAMPBELL: An aspect of
25 that was that many of the drugs that are in fact taken
26 and used in this manner are not abused simply by the
27 fact of their use. The occasional, and he mentions
28 specifically, that the occasional use of cannabis is
29 not to be considered abuse.

30 THE CHAIRMAN: Doctor, there

1 may be another way of putting the question, would you
2 consider any non-medical drug use abuse? I mean our
3 terms of reference require us to look at non-medical
4 drug use presuming this is not applied for a cure.
5 Would you equate non-medical use with abuse?

6 DR. WIGLE: Yes, I think
7 I would. I think that, well, glue sniffing is a non-
8 medical use of a chemical.

9 THE CHAIRMAN: Social
10 drinking of alcohol would be drug abuse?

11 DR. WIGLE: I wouldn't say
12 it was entirely non-medical.

13 MR. CAMPBELL: Are you making
14 reference to the profession when you are saying that?

15 DR. WIGLE: I am speaking
16 as one with a fair amount of experience.

17 THE CHAIRMAN: I tell you,
18 with respect to our definition of non-medical drug
19 use that we had a difficulty in getting one, but the
20 one we have adopted for better or worse is that it
21 is, "use indicated or justified for generally accepted
22 medical reasons, whether under medical supervision or
23 not." This is what we finally had to work out when
24 we were to give a definition.

25 DR. WIGLE: I think that
26 sounds ---

27 MR. HAKES: That includes
28 the self-administration ---

29 THE CHAIRMAN:
30 It has to be indicated for generally accepted medical

1 reasons.

2 MR. HAKES: This would include
3 morphine given by the patient to himself?

4 THE CHAIRMAN: It would include
5 aspirin, but I don't know, though, whether we have
6 considered alcohol.

7 DR. LEHMANN: One could mention
8 the point that it is good medical practice to have
9 alcohol as a social lubricant to produce mild euphoria.

10 THE CHAIRMAN: You mean in
11 accordance with the good practise of doctors?

12 DR. WIGLE: Or lawyers, with
13 due respect.

14 THE CHAIRMAN: We will spare
15 others present.

16 DR. LEHMANN: I notice on
17 your table that you estimate a legitimate consumption
18 of controlled drugs, one item that strikes me, and
19 that is the estimated consumption of amphetamines
20 between 1964, and that is Appendix B, between 1964
21 and 1966 there is an almost 100% increase. And then
22 it goes down again very rapidly and duly comes up
23 again. But have you any explanation for this increase
24 from 506,960 kg. to 965, 433 in two years?

25 MR. HARPER: I don't think
26 we have an explanation for these figures. We obtained
27 them from the Narcotic Control Drug people who are the
28 repository of them. We have no access to them except
29 from them in summary, after the fact. I wondered about
30

1 the same phenomenon when I looked at the data first
2 and I can only assume it can be related to inventory
3 adjustment at year end. The stores don't necessarily
4 have the same stock at the end of one year, depending
5 on what consumption has been, stocks may be down
6 and wholesalers and retailers ordering more, and it
7 may raise the demand in that one period. As a
8 result, the only data that is significant to me in
9 this is the term. If it had been going up then we
10 could say that there was serious concern about in-
11 creasing medical use. But the data doesn't show
12 an upward trend, it shows really, on balance, a pretty
13 level trend.

14 MR. CAMPBELL: Another part
15 of the original table from which this is taken is a
16 conversion of these amounts to standard doses, and
17 the conversion for 1969 was that we had available in
18 Canada something on the order of 67-68,000,000 ^{standard}/doses
19 of the amphetamines, and something on the order of
20 660,000,000 standard doses of barbiturates. Does
21 this strike the Association as being, indeed, very
22 large amounts when expressed as standard doses, where
23 the standard doses of barbiturates --- say 660,000,000 and
24 I think that is a bit low. For the Canadian population
25 this is a very great deal.

26 DR. WIGLE: I don't think
27 we have come to deny there is a problem of abuse in
28 this area, but Mr. Harper may have something to
29 supplement it with.

30 MR. HARPER: I think your

1 conversion is probably generally fairly accurate, but
2 I think we should also recognize that there are also
3 some 8,000 drug stores in Canada, and just working
4 that out, that isn't very large stock for each one of
5 them to have a bottle in each store available to fill
6 legitimate prescriptions when they are required. The
7 drug store just can't keep twelve on hand for the
8 next prescription of twelve, he must buy 100 or 500
9 and inventory them to meet demand when it comes. So
10 that part of these large figures may in fact represent
11 this inventory situation, and I am sure it does.

12 MR. CAMPBELL: I might add
13 that the conversion is not my conversion, the conversion
14 was part of the original table. Have you seen the
15 table?

16 MR. HARPER: Yes.

17 MR. CAMPBELL: In Appendix
18 A and in the brief, you draw attention to relatively
19 low levels of barbiturate and amphetamine advertising.
20 Does this represent a significant change in the
21 advertising practices with respect to these drugs? If
22 you took a similar period of, say, two years ago or a
23 year ago, would the levels of advertising be comparable?

24 MR. HAKES: I think there
25 has been a trend downwards over a period of years. If
26 you went back ten years, you might find a higher
27 indication --- or use of barbiturate advertising. This
28 has been a downward trend for a number of years.

29 MR. CAMPBELL: A downward
30 trend with respect to these particular drugs or with

1 respect to the psycho-active drugs in general?

2 MR. HAKES: Dan, can you
3 answer that? I am not ---

4 MR. HARPER: Our member
5 companies were not informed that we were even taking
6 this survey, so the mere fact I was keeping track of
7 the number of ads that were being run for this, were
8 the only facts they had so could not affect their
9 marketing trends or strategy.

10 MR. CAMPBELL: I am not
11 saying they have.

12 MR. HARPER: But what I'm
13 saying is I looked back at this and went after this
14 data, and I didn't check the medical data from five
15 years ago but it could be checked with anyone who has
16 any access to a medical library, and I think Mr. Hakes'
17 point is valid, probably drawn by our seat-of-
18 the-pants experience, but so far as the psycho-active,
19 and I am sorry I wanted to go on and answer that
20 additional part of your question. When I was taking
21 this retrospective study, I was impressed with the
22 number of psycho-active drug ads, but it wasn't part
23 of our term of reference at the time. I think it
24 would be illuminating for you and for us to do a
25 retrospective study of that area.

26 MR. CAMPBELL: Have you
27 done any analysis of the influence of various types of
28 advertising on drug selections by physicians? Have
29 you studied the impact of advertisement that appears
30 on the page of a journal as opposed to the impact of a

1 brochure contained with a sample, or what the detail
2 many says. Is it your impression for instance that
3 your advertising in journals carries a significant
4 major impact on the drug culture?

5 DR. WIGLE: Just from my
6 point--this maybe discussed in other presentations,
7 but the last surveys that were done indicated the
8 most effective way of getting a message brought to
9 the doctor was through the detail man and it was also
10 the most preferred method, and that the medical
11 journal ads came second to that.

12 MR. CAMPBELL: Well, if the
13 medical journal ad comes second--I have looked at a
14 lot of these as I have looked at a lot of brochures
15 --your brochure or the insert in the package will often
16 contain information, counter reactions or dangers of
17 the drug. It is not frequently the case that your
18 advertisement in a journal contains the same sort of
19 information in a journal.

20 DR. WIGLE: I beg your pardon,
21 sir, but there are two types of ads; one is a
22 reminder in which the company is allowed to list the
23 name of its product just to remind the doctor that
24 that product is on the market, and we cannot make a
25 therapeutic claim in a reminder ad. But if they put in
26 an ad that makes a therapeutic claim, they must follow
27 our schedule and our code in the advertising and we took
28 this up with the Canadian Medical Association--
29 for one journal anyway--and in our own Association
30

1 we police these ads and if a therapeutic claim is made
2 then all information must be on the page.

3 MR. CAMPBELL: And those will
4 continually appear in your journal type of ads?

5 DR. WIGLE: Every time. In
6 fact we are proud of the fact that we have in the last
7 three or four years, through a Committee, policed our
8 own members in this regard, and we have never had
9 anybody yet who refused to accept the decision of the
10 Committee and corrected their ad immediately when it
11 was drawn to their attention that they had erred.

12 MR. STEIN: In looking at
13 the list of the member companies of your Association,
14 it is my impression that quite a number of them would
15 also be members of the other organization that you
16 referred to that would be involved in the distribution
17 of over the counter drugs. Is this a reasonable
18 assumption, that members of your Association would
19 also be, in a number of cases, the same pharmaceutical
20 companies that would be involved in distribution of
21 over the counter drugs?

22 DR. WIGLE: Yes, some of
23 our companies are also members of a proprietary
24 association and produce medications that are over the
25 counter, and usually under a separate division entirely,
26 because the inspection situation is entirely different
27 and the drug is entirely different and usually under a
28 different name.

29 MR. STEIN: Would you have
30 any impression as to the percentage of members of your

1 Association that would also be involved in the other
2 distribution of over the counter drugs--would it be
3 half of your Association, a quarter?

4 DR. WIGLE: I don't think it is
5 that high, but most of us are familiar with those that
6 are prominent in the field. If you could just wait a
7 moment, Mr. Harper will tick off the ones we are aware
8 of and tell you the number out of the total. And
9 incidentally, the question that Dean Campbell asked
10 relative to retrospective study of the advertising, would
11 the Commission like us to undertake some such study and
12 if so, define it a little more closely, because we wouldn't
13 mind doing another little bit of work for you and sending
14 it in written form if it would be useful.

15 MR. CAMPBELL: I don't think
16 I would like to frame a request, as it is off the
17 top of my head. It is something I would like to think
18 about.

19 DR. WIGLE: If you do wish it
20 sir, drop us a note and we will send it back by
21 mail for you--providing we have the mail--or a runner.

22 THE CHAIRMAN: Excuse me.
23 There is a gentleman at the microphone.

24 THE PUBLIC: I would just
25 like to know myself, do any of you take your own
26 products?

27 DR. WIGLE: I'm sure that
28 the manufacturer does, are you thinking of just
29 amphetamines and barbiturates, or all of the prescription
30

1 drugs?

2 THE PUBLIC: Just the ones
3 you get stoned on. Either your product or somebody
4 elses.

5 DR. WIGLE: I don't think
6 there is anybody at this table who would admit to such
7 an abuse, and none of us are distillers.

8 THE PUBLIC: Would you say
9 underground speed is just as good quality if not
10 better than what you are making?

11 DR. WIGLE: If you had an
12 opportunity to look at the quality controls that are
13 used in a responsible pharmaceutical manufacturing
14 house, I think that you would probably have some
15 doubt about what other types of origins it might have,
16 but we have no acquaintance with the quality of, as
17 you call it, underground speed, because we haven't
18 had any chance to analyze it, nor to visit the plants.
19 But our plants are visited and inspected regularly
20 and live up to the Code.

21 THE CHAIRMAN: I was
22 interested in what the brief said about the control ---
23 the quality control against theft. What measures do
24 you take to safeguard against theft, and what measures
25 do you have for identifying theft if it occurs? What
26 kind of records ---

27 MR. HAKES: The plants that
28 are active in dealing with controlled drugs are
29 regularly inspected by the Food and Drug Directorate.
30 They have standards that they require. I don't know

1 exactly what these standards are but I do know they
2 require electronic controlled enclosures. In our
3 particular operation we have photo-electric cells
4 operated devices that are connected in with the local
5 Police Departments, this type of thing, and we have
6 in cages. The doors have to be electrically controlled
7 against burglary. It is that type of protection.

8 THE CHAIRMAN: What measures do
9 you have for the control against inside theft?

10 MR. HAKES: Well, in the first
11 place, we are subject to regular inspections by the
12 Food and Drug---

13 THE CHAIRMAN: No, but you must
14 have very careful inventory control?

15 MR. HAKES: My point is that these
16 inspections are accountable right down, close to the
17 last capsule. This isn't actually possible when you
18 are dealing with the large amounts that we do and the
19 losses that would occur in filling of capsules. I don't
20 know how to answer this because we don't have it

21 THE CHAIRMAN: You do not have
22 any losses?

23 MR. HAKES: There is no dis-
24 crepancy in our report that would indicate leakage of---

25 DR. WIGLE: Mr. Chairman, I think
26 a discussion we had coming down in the car this morning
27 was sort of revealing to me although I am sure would not
28 have gotten into the specific areas of the interest that
29 you just mention right here, but our brief explains to
30 you that a manufacturer receives a hundred pounds of

1 something and he has to account for every bit of that
2 hundred pounds and keep it for something like two
3 years--I found out this morning that when you are
4 handling a controlled drug in a properly controlled
5 plant, it even gets to the stage where having filled
6 the capsules, they sweep the floor and strain the
7 sweepings and find out how much may have been involved
8 there in case there is a loss for a period, so I think
9 all of these are theft controls, really.

10 DR. MORIARTY: I think even the
11 rejects cannot be destroyed unless the inspectors come
12 in and witness the destruction.

13 DR. LEHMANN: Well then assume
14 that the control in the large manufacturer's plants
15 very good and considering the fact that a good deal
16 being stolen, would you think that these thefts then
17 would take place mainly in pharmacies or in doctors'
18 offices or in both, or have you any idea about it?

19 DR. WIGLE: I don't think we
20 have any evidence but certainly to me the conclusion
21 logically would be that it is someplace after it gets
22 out of the plant, and the proper channels and after
23 that it escapes if it is reaching the streets. And
24 think there is good reason to believe that there is
25 fair amount smuggled into Canada, too--which may still
26 be of a quality that would make people say that it came
27 from legitimate sources.

28 MR. HARPER: Yes, Mr. Stein?

29 MR. STEIN: I was only smiling at
30 your colleague. I wondered if he had finished the counting.

1 MR. HARPER: I would say there
2 concerning how many of our members be the ones that
3 would be involved in television advertising of non-
4 prescription products, which is what I think you are
5 after---

6 MR. STEIN: Yes.

7 MR. HARPER: I would say there
8 would be about ten or eleven of our members that might
9 be involved with some other division of their company
10 in this activity.

11 MR. STEIN: Fine, thank you.

12 MR. HARPER: Which is what,
13 about 20%?

14 MR. STEIN: Right.

15 THE CHAIRMAN: Are there other
16 questions---yes?

17 THE PUBLIC: Can you tell me how
18 far does your control go in that process with
19 prescriptions? Does the control check the number of
20 prescriptions that are being written by a certain
21 doctor for one type of drug?

22 DR. WIGLE: I would ask Mr. Harper
23 as a pharmacist as to the way that that is checked--by
24 the R.C.M.P. I believe.

25 MR. HARPER: We do have control of
26 it until it leaves our plant and to ensure that it is
27 responsible, approved, bona fide channels of re-
28 distribution, approved characters, every shipping--
29 not every shipping company is approved--it has to be
30 approved by our officials. Once it is transmitted by
them to their customer, the approved pharmacy, the

1 hospital, the approved controls are effected on him by
2 the Controlled Drugs people. You said do we have any
3 control on it, no we don't have --- but the Control
4 Drug inspector goes in regularly and checks the
5 records in the pharmacy. He monitors the prescription
6 file to see how many prescriptions of what quality
7 have been dispensed and he then checks the purchases
8 of that store for all excesses. He checks this back
9 and there must be a reconciling of results. If
10 there is a discrepancy it must be accounted for.

11 THE PUBLIC: I was thinking
12 of one doctor say, prescribing librium to get a lot of
13 people off his back. So they would get these
14 prescriptions for librium and cash them at different
15 pharmacies.

16 MR. HARPER: I understand
17 that the brief to this Commission by the Canadian
18 Pharmaceutical Association dealt with this matter
19 and their increasing concern with people who run
20 from drug store to drug store to obtain undeserved
21 quantities of medication and I am sure that the retail
22 pharmacists and their Associations across Canada are
23 doing everything they can to prevent this. I know
24 from first hand experience that many ---

25 THE PUBLIC: I am not sure
26 whether you gentlemen would be responsible or not,
27 I am just wondering --- thinking of American television
28 and their advertising, would it be the same chemicals
29 in the States as in Hamilton? What I am thinking of
30 are the sleeping pills and their suggestion that if

1 you are not asleep in twenty minutes, and have this
2 pill. You should be asleep in fifteen minutes. If
3 this was Canada, I know where I could send something
4 to our Advertising Board, but what happens when this
5 is in the States? Is there anyone who could do anything
6 about this?

7 DR. WIGLE: Mr. Chairman,
8 again we are out of our field because we represent
9 the prescription drug industry and it is because of
10 that fact we must be careful to confine ourselves to
11 that field. I would like Mr. Hume to comment.

12 MR. HUME: Mr. Chairman,
13 I was just going to point out to the lady who just
14 spoke that perhaps it is not generally understood
15 that the Association that is presenting this brief
16 manufactures only pharmaceutical products which are
17 dispensed by this (portion inaudible)
18 but the interest is related only to the things the
19 doctor has prescribed. Now there is a prohibition
20 against advertising that sort of pharmaceutical product
21 except in recognized medical journals and not to the
22 public. Generally --- there are some experiences but
23 generally that is no activity of the Association.

24 DR. WIGLE: I think Mr.
25 Harper would like to supplement.

26 MR. HARPER: I should also
27 like to add that there are some substantial differences
28 in regulations between Canada and the United States.
29 The United States only in this last year or so has
30 been trying to emulate the control regulations that

1 we have had in Canada for a number of years. I don't
2 want to make accusations about the situation in the
3 United States as it is a completely different
4 jurisdiction. I think we have to recognize this
5 though, that the sins of our excesses and problems
6 are really emulation and not necessarily automatically
7 transferred to Canada. We have to examine the
8 Canadian scene and see what the facts are here.

9 THE PUBLIC: I realize that,
10 it is just that we are open to the channels and I was
11 wondering where you could place something like this.

12 DR. WIGLE: There is some
13 kind of broadcasting commission, you would have to
14 take that up with them, with respect, Mr. Chairman.

15 MR. HARPER: If it would
16 assure you, I could state that our sister organization,
17 The Pharmaceutical Manufacturers Association in the
18 United States has taken a very strong position relative
19 to drug abuse and they are doing all they can to
20 assist and I am sure the concern you express can be
21 dealt with by them and authorities in the United
22 States to help achieve a solution which will be
23 helpful in our society.

24 THE CHAIRMAN: We will
25 adjourn in a minute for lunch. This will be the
26 last speaker.

27 THE PUBLIC: Gentlemen,
28 it seems to me that somewhere along the line there
29 are these drugs which may be illegally falling into
30 hands into which they are not supposed to fall into,

1 and a report was given that the R.C.M.P. can find no
2 evidence of underground laboratories producing illegal
3 amphetamines, barbiturates or anything.

4 THE CHAIRMAN: Only barbi-
5 turates, not amphetamines.

6 THE PUBLIC: I think that
7 you must be somewhat responsible for the fact that
8 your drugs are falling into the wrong hands and that
9 proper steps must be taken. To me, I think the only
10 step would be looking at the weakest points, and I
11 think one of the weakest points are the people who
12 sell to the pharmacies and drug stores make quite a
13 bit of profit and I think they are very open, if not
14 even under the counter, convincing the people even
15 before going to the doctor that this is the drug you
16 need, that the main communication is not through
17 advertising but through person to person, and this is
18 where the breakdown occurs, and I think that the only
19 real solution to this is some kind of nationalization
20 of the drug industry, so that there is no profit
21 being made, that it is merely dispensed for those who
22 need it. Can we have comments on this please?

23 DR. WIGLE: The only
24 comment --- the only area of the country in which I
25 know the industry is truly nationalized is in Russia,
26 and they haven't produced a new drug in the last
27 thirty-five years, they have all come from free
28 countries of the world, which have an industry which
29 is research based and competes in a common market.

30 THE PUBLIC: But we are

1 not a Communist country, we are a so-called democracy
2 and we are supposed to be concerned with the other
3 people, and in our concern I think we must find some-
4 thing --- some new way of dealing with this, and there
5 are no real alternatives. We still have weaknesses
6 where things can be stolen. But if there was nothing
7 to steal, it would be better, but apparently there
8 are great wonderful things that can be done, so I
9 think that we can only close down where possible, and
10 I think one of the best things is to make a non-profit
11 situation.

12 DR. WIGLE: Mr. Chairman.
13 we are always looking for direction. If there was
14 a method through nationalization of this industry
15 that these leakages would be stopped, perhaps we
16 should know about ^{it,} because the industry could initiate
17 the same methods.

18 MR. HAKES: There are
19 thefts in the Post Office.

20 DR. WIGLE: Someone mentioned
21 there are thefts in the Post Office.

22 THE PUBLIC: I think there
23 would be less case of incidents of people pushing the
24 drugs, the man over the counter being interested in
25 you buying this drug, you know. Like I have got this
26 new certain tablet and it is just the thing because
27 you have got, well, whatever you call it, you can't
28 get to sleep early at night and I think this is where
29 things are going wrong.

30 DR. LEHMANN: The main

1 concern of course is with barbiturates and amphetamines
2 and they are being pushed on the streets, and even if
3 there was --- there was no profit at all in the selling,
4 those who are interested in the non-medical use which
5 is on the street, would still be interested in stealing
6 these supplies.

7 THE PUBLIC: But I think
8 there is a very great danger of the non-medical drug
9 use of people who have their prescriptions, who have
10 Nitol and all these other drugs, and I think it is
11 like the gentleman said earlier this morning, it is
12 a soma, we take a pill if anything is wrong, we take
13 a pill and we have got a million pills to choose from,
14 there is one for everybody, one for you and one for me
15 and we take aspirin or whatever, they are all drugs,
16 and the vast majority of it is non-medical use.

17 DR. WIGLE: Mr. Chairman,
18 I know that you want to adjourn, and I am interested
19 in the suggestion that the Government control or
20 something might correct some of the situations, and
21 I am just reminded of one observation, that there is
22 one drug that is completely Government controlled in
23 Canada, sold only through Government channels, and that
24 is alcohol, and there is five times as much spent on
25 alcohol in Canada as all of the prescription drugs put
26 together.

27 THE CHAIRMAN: But the
28 Government makes a profit, maybe that is what's wrong.

29 DR. WIGLE: I hesitate to
30 believe they would take that motive out if they

1 handled these.

2 THE CHAIRMAN: I think
3 then, we should adjourn.

4 THE PUBLIC: I wonder if
5 I might ask a question of the gentleman who was
6 just speaking. Were you inferring that perhaps some
7 pharmacists are selling prescription drugs without
8 prescriptions? Is this in addition to the over the
9 counter type?

10 THE PUBLIC: I think this
11 probably does exist, although I have no definite
12 proof of this. I think a greater danger, though,
13 is if you have a thing in stock, you are going to
14 want to get rid of it, and even if you want to sell
15 it through prescription, I think if you see the
16 people before they even see the doctor, you know,
17 you have got a fellow and he comes up and says "Well,
18 I have got headaches ---"

19 THE PUBLIC: There are
20 some controls over this both by the Drug Directorate
21 and also the Pharmacists Association.

22 THE PUBLIC: But you
23 can't have somebody controlling it, going to every
24 social gathering, and every time people get together,
25 you can't have some observer from the United Nations
26 making sure everything is okay.

27 THE PUBLIC: No, but I
28 mean if you are concerned about the corner drug store
29 selling drugs that should be on prescription, then
30 sometimes these drug stores are called upon by

1 undercover agents to see ---

2 THE PUBLIC: I think if
3 people do get the prescription, I think it is the
4 selling that goes before the prescription is ever
5 written.

6 THE PUBLIC: I just
7 wondered if you were concerned about that aspect.

8 THE PUBLIC: I am concerned
9 about it, but I have no proof about it.

10 THE CHAIRMAN: Thank you
11 very much. I would like to thank the representatives
12 of the Association, Dr. Wigle and all your colleagues,
13 for your assistance to-day.

14 DR. WIGLE: Thank you, and
15 it has been a pleasure to appear here, sir, and I am
16 just interested in the task that you have and I hope
17 I will be able to slip back here and listen.

18 THE CHAIRMAN: Thank you.
19 We will be back here at 2:30.

20 --- Upon recessing at 1:02 P.M.

21

22 --- Upon resuming at 2:30 P.M.

23 THE CHAIPMAN: I call the
24 Hearing to order now. I call upon Mrs. G. K. Turbitt
25 and representatives of the Hamilton Local Council of
26 Women.

27 Mrs. Turbitt, would you
28 like to be seated at this table, and your colleagues?
29 I don't know if we have enough places.

30 MRS. TURBITT: Yes, there

1 is enough. Are you ready to proceed?

2 THE CHAIRMAN: Yes.

3 MRS. TURBITT: We of the
4 Hamilton and District Council of Women are pleased to
5 be afforded this opportunity to present our resolution
6 to the Commission this afternoon. I am Mrs. George
7 Turbitt, Chairman of the Study of the Non-Medical Use
8 of Drugs Committee, and these are my Committee members;
9 Mrs. May Little who is our President, who will speak
10 to you in a few minutes; Mrs. Edward Wass; Mrs.
11 Geoffrey Beattie and Mrs. Alex Chernenko. Our
12 President, Mrs. John Little, will present an outline,
13 purpose, function and representation of the Hamilton
14 and District Council of Women.

15 MRS. LITTLE: Gentlemen, our
16 organization is a Federation of groups. Forty-eight
17 are affiliated with the Hamilton and District Council
18 of Women, and we are associated with the Provincial
19 Council of Women to the National Council of Women.
20 We are non-political, non-sectarian and work to
21 conserve the highest good of the family and the State
22 and to further the application of the Golden Rule to
23 society, custom and law. This resolution that Mrs.
24 Turbitt will present to you was passed by our
25 Executive and also at our general meeting of the
26 Hamilton and District Council of Women, to be
27 presented to you this afternoon. It is now our
28 pleasure to submit to you our findings, and we trust
29 that this submission will be a valuable addition to
30 the material now being compiled upon which your

1 recommendations will be based.

2 Now I also have a letter
3 here of commendation from our Mayor. May I read it
4 to you?

5 THE CHAIRMAN: Yes.

6 MRS. LITTLE: "Dear Mrs. Little:
7 I endorse whole-heartedly
8 the position of the Hamilton
9 and District Council of
10 Women, in its submission
11 to the Le Dain Commission.
12 I firmly believe that it
13 would be a tragedy for
14 Canada if the use of
15 marijuana were to be
16 legalized at this time.
17 As a father of four teen-
18 aged students, as well as
19 a municipal leader, I dread
20 the possibilities that might
21 ensue if non-medical use of
22 drugs was to be legalized
23 while science is still so
24 ignorant of their effects.
25 I congratulate our local
26 Council of Women on making
27 this submission to the
28 Commission, and feel you are
29 presenting the deep and
30 conscientious desires of the

great majority of our
citizens who are very
concerned about this problem.

Sincerely,

Victor K. Copps
The Mayor of Hamilton"

And now Mrs. Turbitt will
carry on.

THE CHAIRMAN: Thank you,
Mrs. Little.

MRS. TURBITT: We have
many deep concerns in our area of drug use and misuse.
Due to lack of time to become more knowledgeable and
informed and to document our findings we shall hope
to have the opportunity in the future to bring to
you our feelings on legislation as it stands on the
supervision of Drug Manufacturers and other channels
that appear to be pouring lethal drugs onto the Cana-
dian Market. We are aware of the drug manufacturers'
contribution to the Canadian economy but feel they
also have the responsibility to the Canadian Public
to protect them in an area where the said public is
not aware of threats to the health of the nation.

We have found great discrepancy
between legal and medical terms that has caused us
much confusion. We feel the very fact that the law
does not reflect scientific knowledge weakens such
laws.

We would like to urge at this
time that future Commissions communicate their terms
of reference and time of hearings at a much earlier

1 date than is the custom at this time. It is felt
2 that more in depth briefs and resolutions could be
3 prepared and documented if haste were not a governing
4 factor.

5 This statement has been made
6 by Mr. Munro and I will refer to it in a resolution.

7 If Mr. Munro felt so strongly
8 when he said, "Because of the possible health hazard
9 which might result from continued use of cyclamates
10 in foods, their use must be phased out." Is it not
11 reasonable to assume this concern would carry over into
12 the non-medical use of drugs at this time?

13 Dr. Yonge, M. D., President
14 of the Canadian Psychiatric Association, Department of
15 Psychiatry, states that some evidence has been found to
16 point to the fact that the use of marijuana may result
17 in changes in the chemical processes of the brain.
18 Furthermore, more certain knowledge that the use of
19 these drugs induce lasting changes in personality
20 functioning.

21 Dr. Stanley Yolles, Director
22 of the National Institute of Mental Health in his
23 report to the U. S. Sub Committee on Drug Abuse urged
24 that restrictions not be lifted on such drugs as
25 marijuana until, medically speaking, cannabis has been
26 given a clean bill of health.

27 Dr. Joseph Benfarado,
28 Assistant Clinical Professor of Medicine and a physician
29 at the University of Wisconsin Health Centre, states
30 "Because marijuana has potential for producing

1 hallucinations without any other draw back, it must
2 qualify as a dangerous drug."

3 From "Marijuana", Enrich
4 Goode - Edited:

5 Due to the safety and
6 effectiveness of newer drugs, marijuana as a medical
7 utility has become invalid.

8 At the United Nations
9 Commission on Narcotic Drugs in 1963 the French
10 Delegation expressed concern over the high rate of
11 road accidents which appeared to be attributed to the
12 abuse of drugs (particularly cannabis).

13 It is distressing to observe
14 the evidence that funds for crucial research and
15 treatment in many areas of 'involuntary' disease are
16 currently being withheld. At the same time, large
17 sums are being and will be allocated for research into
18 and treatment of problems created by the 'voluntary'
19 non-medical use of drugs.

20 Lincoln D. Clarke, M. D.,
21 states in "Experimentation Studies of Marijuana", and
22 this is a study of the Mayors Act, 1944 in New York --
23 did a study on this, and his quote was "Perhaps the
24 most scientifically valuable part is findings of
25 psychophysical and intellectual tests. Marijuana was
26 found to produce significant dose-related impairment
27 of static equilibrium, hand steadiness, and complex
28 (choice) reaction time."

29 Detriments occurred in overall mental
30 functions and in tests involving memory, number

1 concepts, problem-solving ability; the higher the dose,
2 the more complex the task, the greater the impairment.

3 From the Mayors Report it is
4 stated; "In sufficient dosage, T.H.C., it is a
5 synthetic form of marijuana, can match the hallucinogenic
6 and other psychotoxic effects of L.S.D.

7 The Council on Mental Health
8 and the Committee on Alcoholism and Drug Dependence of
9 the American Medical Association and the Committee on
10 Problems of Drug Dependence of the National Research
11 Council, National Academy of Science reports that
12 cannabis is a dangerous drug and as such is a possible
13 health concern.

14 I am going to quote just a
15 few short paragraphs from this same brief.

16 In many countries where
17 chronic heavy use of cannabis occurs, such as Egypt,
18 Morocco, and Algeria it has marked effect of reducing
19 the Social productivity of a significant number of
20 persons.

21 The fact that no physical
22 dependence develops with cannabis does not mean it is
23 an innocuous drug.

24 Many stimulants are dangerous
25 psychoactive substances although they do not cause
26 physical dependence.

27 Further it states that legal-
28 ization of marijuana would create a serious abuse
29 problem in the United States.

30 If the potency of the drug

1 were legally controlled, predictably there would be
2 a market for the more powerful illegal forms.

3 That some marijuana users are
4 now psychologically dependent, that nearly all users
5 become intoxicated, and that more potent forms of
6 cannabis could lead to even more serious medical and
7 social consequences - these facts argue for the
8 retention of legal sanctions."

9 Our interest in drug misuse
10 are not limited, but today our resolutions deal
11 mainly with marijuana as it seems to be the area the
12 Government is intending to pass legislation on. We
13 feel it imperative for the safety of the Canadian
14 people that such a step be withheld until further
15 research has been accomplished.

16 The following findings were
17 the result of study and research by the Committee of
18 the Hamilton and District Council of Women in their
19 inquiry into the non-medical use of drugs.

20 Resolution: Whereas the
21 Honourable John Munro - Minister of Health and Welfare -
22 stated in March, 1970 in an address to the Grocery
23 Products Manufacturers of Canada in Toronto: "My
24 staff and I often have to make decisions without having
25 before us all the scientific data needed for an
26 absolute unequivocal determination of safety. Never-
27 theless, this is our responsibility and we do not
28 shrink from it. If we consider the health of the
29 Canadian public to be at stake, we must act quickly.
30 In such instances, we cannot permit the public health

1 to be endangered for months or years while we attempt
2 to accumulate all of the scientific data which could
3 be developed on a specific area"; and whereas the safety
4 and health of the public is in grave doubt, perhaps
5 jeopardy, due to the prolonged use of marijuana; and
6 whereas the penalty for possession of marijuana is
7 exceedingly severe at the present time; therefore be it
8 resolved, that the Hamilton and District Council of
9 Women urge:

10 A. That consideration be given to placing the control of
11 the sale and the laws concerning the possession of
12 marijuana under Provincial jurisdiction exclusively
13 and be it further resolved that the Hamilton and District
14 Council of Women urge;

15 B. That the Government of Canada refrain from legalizing
16 at this time the sale and use of marijuana and other
17 drugs for non-medical use.

18 We thank you for the
19 opportunity to express our concerns. We are pleased
20 the Government initiated the setting up of this
21 Commission and we look forward to your report in 1971.
22 Thank you.

23 THE CHAIRMAN: Thank you
24 very much. Would any of your representatives that
25 are present care to add anything?

26 Would you care to say
27 anything at this time?

28 MR. STEIN: I notice that
29 on Page 3 you refer to the fact that you are distressed
30 over the evidence that funds for crucial

1 research and treatment in many areas of involuntary
2 disease are currently being withheld. At the same
3 time, large sums are being and will be allocated for
4 research into and treatment of problems created by
5 the 'voluntary' non-medical use of drugs.

6 But a little later you indicate
7 your concern that there should be this continued
8 increased research in the area of marijuana. I am
9 wanting to clear up some of the controversies. In
10 words, you would like to have---

11 MRS. BEATTIE: We certainly find
12 it distressing, as I am sure anyone does, that there
13 should be the necessity for money, monies which
14 logically could be spent in research and therapy of
15 non-self-inflicted disease and injury. Obviously that
16 money which is, say, \$100,000 which is now being granted
17 to the FDD to use for the synthetic form of marijuana
18 to be used experimentally, that \$100,000 is coming from
19 somewhere, and when the Cancer Society has its programs
20 to raise funds, for research into leukemia for instance
21 you hear of researchers who are--they feel perhaps on
22 the verge of break-through--they always are, and they
23 feel that further personnel cannot be employed, that
24 important things cannot be done, that delays are caused
25 because this or that granting body cannot give them
26 the money they need, or perhaps that a person who
27 depends on an artificial kidney has to go farther down
28 the line on the waiting list because it takes a few
29 thousand dollars to buy an artificial kidney
30

1 MR. STEIN: So it is matter
2 of priority?

3 MRS. BEATTIE: That is a
4 sad fact of life these days. In other words, the
5 self-inflicted problems are drawing away money which
6 could be much better spent.

7 MRS. TURBITT: We were not
8 saying we were against this ---

9 MR. STEIN: Yes, I understand
10 your point.

11 MRS. TURBITT: We were
12 saying we were distressed at this.

13 MR. STEIN: I have one
14 further point. The other question was actually for
15 clarification of your recommendation that legislation
16 should be under Provincial jurisdiction. I wonder if
17 you expand on what it is you have in mind in line
18 with the fact that Criminal Code legislation ---
19 maybe I should let you answer the question. I have
20 the tendency to answer my own questions.

21 MRS. TURBITT: Well, we
22 are going to trade. We are very presumptuous perhaps
23 to suggest to the Government how to run the Government,
24 but we are the Government so we are talking to ourselves.
25 We had felt ---

26 THE CHAIRMAN: I hope we
27 are included in that.

28 MRS. TURBITT: We felt ex-
29 clusiveness should be included in case they divided
30 it and there would be people dropped in between

1 legislation that could not be accounted for, so we
2 thought it should be under one area, exclusively. We
3 thought it should be taken from the Criminal Code, we
4 agreed that our young people are having doors closed
5 on them. We thought a separate marijuana law, because
6 of alcohol being under Provincial, we felt it would
7 come into that category, and have a special marijuana
8 law like we have our liquor laws.

9 THE CHAIRMAN. Do you mean it
10 should be controlled and regulated in a way similar
11 to that of alcohol?

12 MRS. TURBITT: No, I'm not
13 saying that. I'm not saying legalize it. I'm just
14 saying that it is illegal to speed--in a car. But
15 young people do not get criminal records. They are
16 committing an illegal act and we thought that under the
17 Provincial Government perhaps it would still be
18 illegal and there would be specific laws covering---

19 THE CHAIRMAN: In other words,
20 you would advocate that its possession still be
21 prohibited--be illegal, but not be a criminal
22 offense?

23 MRS. TURBITT: That is
24 right. And another thing, we thought that the problems
25 are different in different areas and the police in the
26 particular area are knowledgeable of this, and another
27 thing, R.C.M.P. officers coming to your door have
28 a particular feeling, and if it is a City cop or the
29 Provincial Police, they are a little closer to you
30

1 than the man away up there, and we thought that
2 perhaps this way there would be more communication
3 between the drug users and the police.

4 MR. CAMPBELL: On Page 2 of
5 your recommendation, you say, "the Government refrain
6 from legalizing at this time the sale and use of marijuana
7 and other drugs for non-medical use." I wonder if you
8 would clarify what you mean by drugs?

9 MRS. TURBITT: Amphetamines,
10 barbiturates, hallucinogens. Any of the drugs that
11 are on the market --- I realize that barbiturates are
12 legal at this time, but we were not sure --- you see,
13 this has been a very quick thing and we were not sure
14 that marijuana was the only thing that the Government
15 was contemplating taking steps on, and we would felt
16 we would cover that by saying to you that ---

17 MR. CAMPBELL: Well, you see
18 the thing is there are a great many drugs that have
19 demanded society to use non-medically. For instance,
20 alcohol is an extremely potent psycho-active drug. A
21 great deal of social use, would be non-medical drug
22 use. Would you imply that alcohol use should be
23 prevented as a non-medical drug use?

24 MRS. TURBITT: That was
25 not included in this brief. We did not put alcohol
26 in drugs because our generation had never thought of
27 alcohol as drugs. We are just new in this area, we
28 are coming in cold, trying to understand, trying to
29 find out what is going on, and in high school as we
30 were coming up, we were not told alcohol was a drug,

1 stay away from it. We weren't told anything about it,
2 it wasn't even mentioned. Not because we were so good.

3 MR. CAMPBELL. What is the
4 criteria then that you are applying to the selection
5 of drugs that you wish to see prevented?

6 MRS. TURBITT: Marijuana ---
7 and we were not sure of your position, whether it was
8 just marijuana that legislation was going to be made on,
9 and we felt that this information would be perhaps
10 forthcoming even before we came here. All we have had
11 said back to us is that marijuana is being considered to
12 be legalized, but we didn't hear anything else and we
13 were afraid that perhaps other drugs would be brought
14 in under the same Act. The same way as homosexuality
15 which has nothing to do with abortion, but they came
16 in on the same Bill.

17 MR. CAMPBELL: Do you have a
18 criteria, though, for thinking about drugs that makes you
19 want to bring some drugs into this category of drugs
20 that you are talking about here? Are there characteris-
21 tics of the particular types of effects of drugs that
22 make you feel they should be prevented from use?

23 MRS. TURBITT: Well, this is
24 what we thought about marijuana. If in a certain length
25 of time these young people and yourselves can prove to
26 us that marijuana is not harmful, we will accept it.
27 And if you can prove to us any drug is not harmful ---

28 MR. CAMPBELL: Well, a lot
29 of people have said this --- "if a drug is not harmful".

30

1 Actually the truth is that you cannot say this about
2 anything. You cannot say that salt is not harmful. If
3 you take enough salt it will kill you. If you take
4 enough water, it will kill you. And so a very important
5 question is, what is our criterion of not absolute
6 safety but of relative safety or relative danger. And
7 I notice that you cited that Dr. Yolles, I think, on
8 Page 3 on Background Material, and he used the phrase
9 -- "given the clean bill of health." What would you
10 think of as constituting a clean bill of health for a
11 drug?

12 MRS. TURBITT: I think it
13 would have to be that instead of one young man getting
14 up and saying a certain doctor in the States says
15 marijuana is not harmful --- we have been reading like
16 mad, we have read of hundreds of doctors who have said
17 it is harmful. I think if the balance were a little
18 more to the other side, then we would accept it ---
19 we are not saying 100% but we could --- if it is 64% ---
20 this is a personal opinion, now you realize. In other
21 words if the balance were not 50 to one or 100 to one,
22 that we would be more willing to accept it as relatively
23 safe. But in all of our research, which we have done
24 very quickly, I admit, but we haven't found and we
25 have looked and we have talked to students, and we
26 have gone door to door, and we have looked everywhere
27 but we have not found a reliable body who will say
28 that it is harmless

29 MR. CAMPBELL: I don't think
30 that anyone can say anything is harmless, for it is not

1 a question of whether something is harmless, but what
2 are the relative dangers. When you say relatively
3 harmless, are you thinking of harmless at the level of
4 relative danger as of say water or the relative danger
5 of tobacco or the relative danger level of alcohol, or
6 relative danger level of salt? Now all of these things
7 have level of danger against certain types of function.
8 Have you given any thought to a criteria by way of
9 comparison to other substances?

10 MRS. TURBITT: I can't say
11 that I have, have any of my Committee?

12 MRS. CHERNENKO: We have given
13 it thought to the extent that we know research is
14 being done on a synthetic drug and we don't have any
15 standard set down at this time because nobody has
16 set down a standard. If there was a standard, we
17 could know the purity even of marijuana; amphetamines;
18 barbiturates, we know to a certain level--pharma-
19 ceutical companies know about these, but we don't know
20 about a marijuana standard and if there could be a
21 standard set this way, a guideline or standard set
22 this way--this is what I think Mrs. Turbitt is
23 saying, that we would have to--if somewhere we
24 could get a balance line or standard set out, then
25 we would know what the safety factor would be or would
26 not be.

27 DR. LEHMANN: Just continuing
28 a little on the safety or hazard factor, what would you
29 consider to be most dangerous or most harmful; physical
30 damage such as loss of weight and loss of resistance to

1 infectious disease and so on, and damage to the
2 personality or to the mental health, or damage or harm
3 to society through anti-social acts, increased violence
4 I suppose all of these are harmful, but where would
5 you place the first emphasis?

6 MRS. CHERNENKO: On physical
7 well-being, do you mean dehydrated and run-down ---

8 DR. LEHMANN: For instance,
9 speed will probably produce mostly physical damage.
10 Now would you say then that that is why speed is most
11 dangerous, or if LSD will produce mental damage ---

12 MRS. CHERNENKO: I think
13 mental damage --- you could always repair physical
14 damage. Mental damage. I think I would class that as
15 more hazardous than physical damage, really.

16 DR. LEHMANN: Then what
17 about anti-social behaviour, violent activities for
18 instance?

19 MRS. CHERNENKO: I think
20 this comes out as a mental attitude, really.

21 DR. LEHMANN: So these two
22 would take precedence?

23 MRS. CHERNENKO: For me, yes
24 I don't know about the rest of my colleagues here, but
25 for me it is the mental.

26 DR. LEHMANN: Would you feel
27 there is also some moral issue involved or would you
28 disregard this?

29 MRS. CHERNENKO: May I
30 speak for myself?

1 DR. LEHMANN: Yes.

2 MRS. CHERNENKO: I have
3 talked with young people and I have felt that we as
4 adults have been classed as the older generation and
5 cannot set up morals for the juvenile --- young people.
6 I find that the young people have a harder set of morals
7 than we as older people do, towards our own age group.
8 And immediately you start talking morals to the younger
9 generation, they shut you off, and I have found this
10 more and more, and so I can't say myself that there is
11 a moral issue here because their moral issue to me,
12 and I really listen to them, is far harder than my
13 moral issue to them is.

14 DR. LEHMANN: So you feel
15 you do not speak the same language and you do not
16 feel that you should take any authority to assume ---

17 MRS. CHERNENKO: I feel I
18 am in a very good position, I am in a very good position,
19 I get along very well with youth. I think I can do
20 this. But they say that the older generation can't
21 do this, the older generation shuts them off. They
22 cool out of it.

23 DR. LEHMANN: Do you accept
24 this as being valid, or---

25 MRS. CHERNENKO: I have seen
26 it done and so I have to accept it.

27 MRS. BEATTIE: Could I
28 speak to this too? I feel there have always been
29 differences between ages, and there has always been
30 a difference between parents and children, but I don't

1 think people really change, I think the basic needs of
2 every human being always has been and always will be
3 precisely the same, the basic needs. The thing that
4 distresses me today is that from my reading and from
5 my education and by observation, it strikes me that
6 this is perhaps the first generation that has had a
7 significant proportion amongst it who despair of life,
8 who really don't look forward to growing up and who
9 have a despondency which is not characteristic usually
10 of young people or hasn't usually characterized young
11 people even in times of terrible stress that humanity
12 has gone through from time to time. And I know some
13 of the reasons for this, some of the philosophical and
14 sociological, psychological reasons for this, and I
15 think it points something out to us as grown-ups that
16 everyone of us must bear a responsibility for, and
17 that is simply to make life seem worth living to the
18 young people who are under our influence. We must
19 advertise that life is worth living, and I think there
20 are an awful lot of grown-ups who perhaps by their
21 material orientation, by their preoccupation with things
22 that young people instinctively rebel against as
23 being worth while preoccupations for life, that of
24 gaining things; if we give them the impression that
25 this is the most reason for being alive, that there
26 isn't any overall outside purpose in life, that it is
27 something bigger than ourselves, that it is exciting
28 and occupying, we are sacrificing for, then we are
29 doing young people a great injustice and I don't think
30 we can relieve ourselves of the obligation of the

1 responsibility to set examples. I know the other day
2 we were talking about youth --- the peer groups setting
3 examples for one another. Whether we deny it or not,
4 we do look at and we are shaped by and we do follow
5 examples; it is human.

6 MRS. TURBITT: I would just
7 like to add that there is no moral issue in this brief,
8 that I personally have my morals, I resent anyone
9 attacking them; I respect that the young people have
10 their morals and the brief does not in any way intend
11 to moralize.

12 THE CHAIRMAN: Do I understand
13 then, that you would take the potential for harm as
14 the criterion, public policy here?

15 MRS. TURBITT: This is true,
16 yes.

17 THE CHAIRMAN: And you are
18 satisfied from what you have read that there is a
19 serious contention, scientific contention and
20 professional contention as a potential for harmful
21 marijuana?

22 MRS. TURBITT : This is
23 what I feel at this point.

24 THE CHAIRMAN: Your brief
25 not simply just based on the assumption that nothing is
26 known or that there are no valid opinions on marijuana?
27 It is based on an assumption that the weight of opinion
28 is that there is a potential for harm.

29 MRS. TURBITT: And we are
30 only asking the young to wait and we feel that the

1 picture has changed. We admit when we first began, we
2 were panicky and we had closed minds. Whether they
3 know it or not, the adult population --- they must
4 know, we are changing legislation, we have changed the
5 Identification Act, we are changing all kinds of Acts
6 to help the young, and we feel that now it has reversed.
7 We are trying to be open-minded, we have calmed down,
8 try not to panic. The young people are closing their
9 minds and saying, not in the future, now. And we feel
10 that we have sort of reversed roles all of a sudden.

11 THE CHAIPMAN: Excuse me.
12 Yes? Gentleman at the microphone? Can you get to
13 the microphone?

14 THE PUBLIC: I would ask
15 the same question I asked a man this morning, do you
16 take barbiturates?

17 MRS. CHERNENKO: No.

18 THE PUBLIC: I don't know
19 where you got your information but a lot of it is a
20 lot of bunk, and I got my information from the
21 Drug Research on James Street today and a lot of it
22 is bunk. I think I did get a few facts out of the
23 library, and I would ask you people if you would
24 agree with me. One was a study in India where
25 1200 people were on a study, and none of them had
26 effects from marijuana, and there is no evidence in use
27 of marijuana products of any direct brain damage,
28 and I got this from Mind, Drugs, Body, some lady that
29 is over at the library anyway.

30 MRS. CHERNENKO: Wasn't this

1 a controlled --- this was a controlled atmosphere
2 taking?

3 THE PUBLIC: Pardon me?

4 MRS. CHERNENKO: This was
5 controlled atmosphere taking you are talking about in
6 those books.

7 THE PUBLIC: They didn't
8 take a lot, it was just moderate taking.

9 MRS. CHERNENKO: Moderate
10 taking, yes.

11 THE PUBLIC: Yes.

12 MRS. TURBITT: May I answer
13 this. In the Mayors Report that I mentioned, this
14 study was done in New York, and as I say, the doctor
15 who mentioned it said the only good thing that came
16 out of it was this little portion that I read. But,
17 why they took it was, because the population became
18 panicky over sex and violence in New York, and so to
19 appease the people they took the study, and they came
20 up with a very permissive bill saying, "Marijuana does
21 not cause violence, marijuana does not cause an increase
22 in sexual desires." But they took it on prisoners in a
23 welfare hospital. How can you be violent with a
24 policeman there with a gun on you? I mean, I didn't
25 feel it was a fair study, and I feel that any studies
26 we are quoting we would have to look into further than
27 just ---

28 THE PUBLIC: Most of the
29 people I know would rather sit around and wouldn't
30 cause a fight on marijuana. On speed or something

1 they would cause a fight.

2 MRS. TURBITT: They would?

3 THE PUBLIC: Yes

4 THE CHAIRMAN: Gentleman at
5 the microphone there?

6 THE PUBLIC: I believe the report
7 you are talking about is the Mayor La Guardia Report
8 of 1939. Also, if you recall the (inaudible) Report it
9 showed in many instances that if they were taking normal
10 type doses which was 2 cc. of liquid--well, in a
11 concentrated form like T.H.C., in the biggest majority
12 of them, there was no effect that would prove to be
13 harmful to a person. In many cases in putting them
14 through all sorts of vigorous types of things, the
15 mental capacity of a person increased in a lot of
16 cases. In some cases it showed a slight decline, but
17 nothing anybody could really complain about, and a lot
18 really stayed normal. This is under the influence of
19 2 cc. Now they tried the same conditions under the
20 influence of 5 cc. and it proved, like they over-dosed,
21 which is normal on just about anything you do. If you
22 overdose, you are going to run into problems. Well,
23 with the 2 cc. they didn't overdose and everybody seemed
24 to get along quite well, and the report afterwards,
25 which you came up with, in 1945 by the doctor, was a
26 complete farce; the whole thing was a complete farce
27 I mean there was a whole team of doctors, psychologists,
28 sociologists, everything that went in to it to study
29 the human body and mind, and they came up with exactly
30 the same thing. But when it came to Congress to be

1 voted on everybody sort of looked at it and sneered, and
2 it was pushed aside, and there was only one person
3 from the American Mental Association that was called
4 to stick up for it and everybody else that was to talk
5 on it were nothing but veterinarians and people like,
6 for example, the person who was a pigeon raiser in the
7 United States gave his pigeons marijuana seeds to make
8 their feathers grow better and he was worried about ---
9 he was worried about the seeds being sterilized
10 because maybe their feathers wouldn't grow as well as
11 they should. Now there were all sorts of things
12 like that in the report.

13 I mean, what are you supposed
14 to believe when you see a report like this?

15 MRS. TURBITT: This is what
16 I say.

17 THE PUBLIC: What are you
18 supposed to believe?

19 MRS. CHERNENKO: Which
20 report are you talking about?

21 THE PUBLIC: Mayor LaGuardia
22 report set up by Mayor LaGuardia in 1939.

23 MRS. CHERNENKO: We are
24 talking about the 1944 report.

25 THE PUBLIC: The 1944 was
26 the follow-up.

27 MRS. CHERNENKO: You said
28 on 2 cc. there were no ill effects?

29 THE PUBLIC: No effects.

30 MRS. CHERNENKO: On 5 cc.

1 there was definitely ill effects.

2 THE PUBLIC: Over dosing.

3 You overdose on aspirin and you hurt yourself.

4 MRS. CHERNENKO: This is what

5 I am saying. All this research has been done in a
6 controlled atmosphere. This is what we are saying.

7 THE PUBLIC: Okay, it is a
8 controlled atmosphere, but look who they are using ---
9 they are using convicts.

10 MRS. CHERNENKO: Convicts.

11 We also stated this.

12 THE PUBLIC: We are talking
13 about people off the street who are not criminals,
14 they are using actual convicts, the scum of society,
15 supposedly.

16 MRS. CHERNENKO: We just
17 said that, we just finished saying that.

18 THE PUBLIC: Yes, but they
19 came up with this set of conclusions with convicts,
20 what sort of conclusions are they going to come up
21 with normal people?

22 MRS. CHERNENKO: As Mrs.
23 Turbitt just said this was done in a confined area
24 with armed guards standing over them.

25 THE PUBLIC: Also in this
26 report they had prisoners in the jail who also gave
27 their view points on it. Like there was one guy in
28 jail for possession of marijuana, he was serving a
29 twenty month stay, and he was there for the possession
30 of marijuana; right? So, okay, he was really upset when

1 they found out these convicts were coming back, said
2 they were not mistreated, everything was well under
3 control and he felt bad because of the fact he had to
4 spend twenty months in jail because of something they
5 could not find anything about. I mean they went over
6 these guys from top to bottom, every square inch of
7 their body, and they still came up with the same sort
8 of thing. The report was in favour of legalizing it,
9 but nevertheless they still went ahead and made it
10 illegal and all the testimony that was put forth to
11 them was nothing more than hearsay whereas the report
12 was nothing but genuine fact and everybody seems
13 to nowadays look at the genuine fact and push it aside,
14 and the hearsay they will go along with.

15 I can't understand that at
16 all.

17 MRS. WASS: Excuse me
18 isn't this what we are saying today. With some of this informat
19 on one side and some on the other, we are willing to
20 accept anything. If these people get together and bring
21 forth some good concrete information. We haven't
22 closed our minds, we are aware that there are these
23 situations. This is what I am saying.

24 THE PUBLIC: There is good
25 concrete information coming out back as far as 1884
26 from the Isthmus of Panama, like they were building the
27 Canal and the people down there were smoking the
28 cannabis. So they decided to find out what it was
29 about, and they put a team of doctors in the same
30 sort of thing and they came out with the same sort of



1 findings and there have been many other reports along
2 --- and they all seem to follow the same line, but
3 nobody listens to the reports that there is medical
4 advice on.

5 MRS. WASS: We are reading
6 really, honestly and we are trying to gather as much
7 information as we can.

8 THE PUBLIC: Yes, right.

9 MRS. WASS: If we haven't
10 got to that yet, we are getting to it, and this is the
11 very reason we are asking them to wait.

12 THE PUBLIC: We have been
13 waiting for a long time.

14 MR. TURBITT: Since 1800?

15 THE PUBLIC: Marijuana has
16 been around since the beginning of time, it was
17 around before alcohol was, I'll tell you.

18 MRS. WASS: I like cyclamate
19 in my coffee too, but I am stuck.

20 THE CHAIRMAN: Gentleman
21 at the microphone?

22 THE PUBLIC: Yes. Most of
23 it was pretty well covered except I think, you know,
24 it really has to be stressed that there have been the
25 three major reports, the one by the British Government
26 in 1897, the one by the American Government in the
27 Isthmus of Panama around 1884, and the Mayors Committee
28 on Marijuana in New York City which started in 1937
29 and ended some time around 1941 - 42. Now, all three
30 of those reports came out showing that marijuana was

1 not the killer drug and all this garbage that the
2 boys in the Narcotics in the States made it up to be.
3 They showed that it was indeed a social crime and
4 usually the people who were smoking it were those who
5 were in prison--and by the way they were not under
6 armed guard; I read the report whether they were in
7 prison or sitting around little tea pads or whatever
8 the names you want to call it, just somebody's room,
9 they tended to be sociable. There was obvious lack of
10 violence among this group of people, and then all
11 three of these reports, they were shoved under the
12 table and people wouldn't listen to them because they
13 had been scared by the posters and all this garbage
14 that had been put out. And the fact that marijuana
15 hashish have been used for over 3,000 years in the East
16 and in various other countries without any serious
17 impairments coming to the people, you know, shouldn't
18 that be enough proof, in 3,000 years? And don't
19 try to tell me--you look at Morocco and the country
20 is all in a shambles because of marijuana. Because
21 that is bull. Because it is because of the country--
22 it is the type of soil, it is the type of temperature,
23 it is the type of climate, it is a lot of things
24 together, and it is certainly not just marijuana.

25 MRS. TURBITT: We agree with
26 you there because we have invalidated a great deal of
27 our material because it came from those areas. But
28 think you will find that when a report is made or when
29 it is instigated, it is instigated for a purpose and the
30 purpose of this was to appease people. This is why it

1 was put out. Naturally, there findings were going to be
2 geared that way. You said it was a farce, we say
3 was a farce,

4 THE PUBLIC: Which, the doctor?
5 The doctor's report?

6 MRS. TURBITT: I didn't give
7 great long paragraphs because I realize the time
8 element. I have a big set of books there if you want
9 to read them. We are just doing our best to understand
10 --this is what we are looking for, understanding with
11 you, not against you.

12 THE PUBLIC: But the thing is
13 that people can't learn to understand more about it
14 and they can't learn more about it outside the controlled
15 situation. Yet they will always worry that the next
16 day they will be hauled off as prisoners for the
17 rehabilitative process.

18 MRS. TURBITT: Well we agree with
19 that and that is--unfortunately there is still a lot
20 of grey area and the Identification Act is trying
21 be changed so the young people do not have this, and
22 we are agreeing this is a bad thing.

23 THE PUBLIC: Wouldn't it be
24 better to put it under the same area as alcohol?

25 MRS. TURBITT: Not at this time
26 At this time, we know.

27 THE PUBLIC: And we could also
28 enjoy it at the same time. Because I really dig it

29 MRS. TURBITT: Well, a great
30 deal of our young people are using alcohol with

1 marijuana. You are just saying, "well what these kids
2 said is not so", but I'm ready to believe you and I'm
3 also ready to believe them, so I'm just saying, at this
4 time, bring us all your information, or this Commission
5 bring them the information; they are open minded, they
6 are not even mothers.

7 THE PUBLIC: Can I suggest
8 something you might find useful, it is called the
9 "Marijuana Papers" and it is edited by David Solomon.
10 It has pretty well set every report you have read on
11 its backside and probably show you---

12 MRS. TURBITT: Why are you not
13 up here, sir?

14 THE PUBLIC: Why am I not up
15 there? Because I haven't had the research background

16 MRS. TURBITT: We were not
17 aware of this information.

18 THE PUBLIC: When you were
19 reading these other books, didn't you come across--
20 when I first started to think about marijuana, I wanted
21 to know what I was doing and so I looked, "M" under
22 drugs, marijuana. And this book was really great:
23 it sets out things very straight and it doesn't have
24 this scare stuff in it.

25 MRS. TURBITT: Will you quote
26 your authority, sir?

27 THE PUBLIC: David Solomon,
28 "Marijuana Papers"

29 MRS. TURBITT: Well as soon
30 as I'm in--I mentioned that when this Commission

1 was coming we found it was too late to do an in-depth
2 study and so we got all the information we could, and
3 unlike you, we had to run home and do dishes and things
4 like this. You can stay at the library. But if your
5 mother stayed at the library you would be made if your
6 supper wasn't made.

7 THE PUBLIC: I used to have to
8 make my own dinner, my mother was out working.

9 THE PUBLIC: I would like to
10 add one aspect to the ladies' case which was covered
11 by the gentleman at the other microphone, briefly, but
12 you made reference to behaviour of people in the
13 Eastern countries such as Morocco, and concluded from
14 this that their behaviour was attributable to their high
15 use of marijuana. I would suggest that perhaps not only
16 conditions that the other gentleman outlined but also
17 the intrinsic cultural differences between Western
18 Society and societies in that part of the world, perhaps
19 might also offer some light for this type of behaviour.
20 Their lethargy I think--that is the word you used.

21 MRS. TURBITT: Yes, we quoted
22 this from a book. But as I say, all the information
23 we got on this we invalidated because of cultural
24 differences. We found no research study in any of
25 those countries due to the difference that would be
26 valid here.

27 THE PUBLIC: There is a very
28 recent book out, that perhaps in light of your comment
29 of mutual understanding, I would recommend for you
30 perusal, and that is "Drugs and Law, the Canadian Scene"

1 by Whittaker and I don't know the name of the book but
2 in his work, includes an in depth look at the study
3 the other gentleman referred to, the Marijuana Papers,
4 along with just about everything else that has been
5 written in a very nice concise style. Both sides
6 have been written in a very wide, mostly disciplinary
7 approach.

8 MRS. TURBITT: We have that
9 book and we did read it.

10 MRS. CHERNENKO: I have that
11 book and I read, well I did not read it all, I did
12 not have time, but I agree with you to the extent
13 that the laws definitely need to be changed, even in
14 our own area, they need to be changed and there is
15 action being taken on this. But as far as Marijuana
16 and the Law is concerned, I can't say anything to you
17 that would satisfy either me or you right now.

18 THE PUBLIC: I don't feel
19 for you if you don't feel for me. (portion inaudible)

20 MRS. CHERNENKO: I indicate
21 that you had probably read Marijuana and the Law to the
22 full extent and I have not done this so I can't relate
23 back what was in that book --- Marijuana and the Law.

24 MR. STEIN: You have referred
25 to changes in the law that apparently are going on. I
26 am not quite sure what you are referring to. Perhaps
27 we can --- maybe I do know --- are you referring to
28 the criminal structures?

29 MRS. CHERNENKO: To the
30 Criminal Code, also in our own --- what is called the

1 Identification Act, is now being changed, where a young
2 person of today is being picked up and immediately
3 finger-printed, height taken, weight taken, picture
4 taken and they have a number, and if they come up on
5 a summary conviction; too bad. They are already a
6 criminal. This is being changed, and is now being
7 put into effect. This won't happen. They won't be
8 put through the identification rigamerol, as they call
9 it until it has been decided what has been going on,
10 if it is a summary offense or inditable.

11 THE PUBLIC: One question
12 I would like to ask, is do they plan on destroying
13 those they already have?

14 MRS. CHERNENKO: This I
15 don't know, I am hoping this is what would happen.

16 THE PUBLIC: This would
17 seem natural to me. I was going to mention one other
18 thing. Mr. Campbell referred to --- he was trying to
19 discover which criteria you though the most important ---
20 physical damage, social damage, and just to deal with
21 marijuana and the present drug laws and the anti-social
22 sort of ramifications of the law, I suggest you might
23 read Eldridge Cleaver, "Soul on Ice," and in the first
24 few chapters he mentions that he is in Folsom Prison
25 for --- his first offense was possession of marijuana.
26 This was the very beginning of his whole alienation in
27 the white society that has oppressed the Negro for
28 so long, that the white man sat there with his
29 alcohol and put the ghetto Negroes in jail for doing
30 what came to them as natural which their forefathers

1 did before them and jailed him for that. And then you
2 might read Robert Fulford who wrote an article in, I
3 believe, October or September of Saturday Night which
4 is a Canadian paper, and he mentioned that when people
5 like James Mackey or any of these people in authority
6 make a statement on marijuana --- or Harry Anslinger
7 previously to '62 was the U. S. Commissioner --- Head
8 of the Bureau of Narcotics, I believe, for the United
9 States --- who made the statement like a man smoked a
10 cigarette, raped five women and it took ten policemen
11 to hold him down --- stuff like this. All it really
12 does is just to convince kids that they can't believe
13 what authority says, and so you get this over-reaction
14 from this and then something dangerous comes along,
15 something like amphetamines that nobody really realized
16 the abuse problem^{that} was going to result, and now they
17 say, "don't take it, it will really mess you", and a
18 lot of hip people know it will mess you, but the kids
19 have heard it all before about marijuana, and they
20 didn't believe it because they knew it wasn't true,
21 and the thing that you ladies have to understand
22 is that every kid in this audience --- we could be
23 wrong and be right out in left field, but you won't
24 convince us that we are wrong. We have seen where the
25 law has been wrong and we have had lies told us, whether
26 maliciously or whether unintentionally, for what they
27 thought might be our own good, we have seen the lies
28 and we know^{they are} lies, and I think after somebody has
29 told you a lie once, you tend to take things with a
30 grain of salt, you know.

1 MRS. CHERNENKO. I agree
2 with you, but don't you feel now, that we are opening
3 up. We feel we are opening up.

4 THE PUBLIC: I think you
5 ladies--considering the amount of research you did,
6 I think you have come up with better than I would have
7 expected. Seriously, look, I don't mean it as an
8 insult but I know what I expected, and it was a lot
9 more enlightened. But the thing is if you find you
10 don't have--read Dr. Jeol Fort, there are a lot
11 of people who have written--I don't think you get
12 as wide a circulation when you write, let us say,
13 something unpopular with the majority of the people.
14 The librarians in Hamilton aren't going to bring in a
15 study that says "Listen, it's good, go out and do it"
16 But I really think that you have this element of--if
17 not censorship, a sort of repression where certain
18 things will be held back from general knowledge.
19 Certainly, our glorious newspapers of the area, they
20 take a marvellous editorial stand, really clever.

21 MRS. BEATTIE: Have you read
22 the brief prepared by the Ontario Alcohol and Drug
23 Addiction Foundation for this Commission?

24 THE PUBLIC: I have read
25 some of their literature--no.

26 MRS. BEATTIE: I would
27 advise you to read it as an example of calm, objective,
28 scientific, unexcited and unprejudiced, serious work
29 on the subject. I respect very much what they have
30 written for this Commission and I think that if you

1 haven't read it, anyone in this room would be ill
2 prepared to speak on the subject.

3 THE CHAIRMAN: As a matter of
4 interest, have they published it--I did not know that
5 they had published it.

6 MRS. TURBITT: We were allowed
7 to read it in the library and to have a small copy of it

8 I would just like to say, you say
9 that we will never convince you that you are wrong,
10 and I don't think many of us are. We are not asking
11 you to say you are wrong, we are asking you to search
12 for answers with us, and this is all that we want to
13 do--and if they prove--not beyond a doubt, but even if
14 it swings the other way to where it is now, and you
15 young people--go ahead, prove it, and we will help you
16 get legislation if we can find that a few years from
17 now you are not going to suffer because we weren't
18 responsible enough, and we have been around the bend--
19 I shouldn't say that--we have been around the bend, we
20 know there is a pot hole there and you are coming and
21 saying it's not there I can't see it. But if you swing
22 left or right you might miss it, and this is all we
23 are trying to do, and if we were not interested in you,
24 we would be at another Commission asking them to up
25 the Old Age Pension. We almost were. We are here,
26 interested in you.

27 THE PUBLIC: Well I think
28 the real basic issue, I think it goes a lot deeper
29 than the one thing, that the one thing politically
30

1 conscious people of my age want is a return of humanity
2 to Government. I think so many times Government
3 has gone out of control of the people and it is in
4 the control of vested interests. I don't think
5 Canada is as bad in this regard as the States, but
6 I really think you have got to get a return to where
7 a politician will say, "Well, that is what my people
8 want, and maybe it is not in my best interests, and
9 I may lose some campaign funds and I might even lose
10 my election, but that is what the people want". I
11 just don't know. So many times I feel that the
12 people who are running the Government are not really
13 in touch with what we want. And I don't mean me or
14 just people my age, but I mean Old Age Pensioners,
15 people in the minority, because we don't have the
16 money, the lobbying power, because all we have is
17 ourselves and the spirit, and the spirit, we won't
18 let it be broken.

19 MRS. TURBITT: Are you
20 suggesting women go into Government?

21 THE PUBLIC: Sure. You
22 know, certainly take a more active part.

23 THE PUBLIC: Yes, I would
24 like to ask the Commission first off, what was done in
25 the way of investigation before the anti-marijuana
26 laws were brought into action?

27 THE CHAIRMAN: Well, we
28 should be careful about expressing findings and
29 certainly not disclosing any of our conclusions
30 at this time.

1 THE PUBLIC: I know. I
2 believe the law was set in 1923.

3 THE CHAIRMAN: In 1923 it
4 was added to the schedule, yes. There was no evidence
5 of any particular inquiry or scientific study,
6 certainly not an inquiry of this kind.

7 THE PUBLIC: No. And in
8 the light of that these women are asking for such an
9 intense survey before the law is taken out; in the
10 lack of a light of the survey when the law was brought in, I
11 think it would be logical to have some kind of a hold
12 on the law until there are adequate surveys, as there
13 is no evidence at the present against the use of
14 marijuana. I am not endorsing the use of marijuana
15 by any means, I don't endorse the use of any drug,
16 but in the light of the number of people who are
17 winding up in jail with criminal records and so on,
18 I don't think that there is much point in maintaining
19 the law as it presently stands until we do have
20 sufficient studies, and that again, is up to the
21 Government to ensure that these studies are done.

22 DR. LEHMANN: May I ask
23 you whether you would be still in favour of legislation
24 or legalization, rather, if it could be shown, if
25 it would be shown that cannabis is quite a
26 dangerous drug? Would you still feel it should be
27 legalized?

28 THE PUBLIC: I would have
29 very tight controls. As far as I am concerned, you can
30 make no drug illegal. If somebody wants it, they

1 are going to get it, no matter what that drug is. If
2 you think you couldn't get heroin, it is just a matter
3 of if they couldn't get heroin anywhere else, they would
4 grow their own poppies and learn how to cure their
5 own opium to get their own heroin. So you are not
6 going to be able to stamp out those drugs, and you are
7 going to involve a lot of the taxpayers time and money
8 in pursuit of a few little junkies who are going to be
9 anti-social in their own little environment without
10 too much coming in contact with that society they are
11 being anti-social to. So I think that if marijuana
12 was found out to be highly dangerous, that you would
13 merely have to have extreme restrictive controls on it
14 much as they have on heroin in Britain. I think that is
15 a valid idea the way they are doing over there with
16 extremely tight controls, maybe even tighter, I don't
17 know. But there is no point in making it unavailable to
18 the people. They are going to go on and do whatever they
19 can, and in the end they might end up killing themselves,
20 and we will think, we will think, "that is really great,
21 at least they got out of our society, that was nice
22 of them to kill themselves", but I don't think that's a
23 good idea to have. I think we should maintain them
24 until they can realize on their own what they are doing
25 to themselves.

25 DR. LEHMANN: I see. Well,
26 may I ask these ladies then, because you just said,
27 provided evidence is coming out that marijuana is not
28 harmful, or not very harmful, that you might change
29 your view and might be in favour of the legalization
30

1 MRS. TUREITT: Yes.

2 DR. LEHMANN: What kind of
3 evidence would this have to be? As you admitted, any
4 drug is harmful if taken in too large a dose, and we
5 heard it from several people here in the audience,
6 if
7 that sure, that hashish or marijuana is taken in doses
8 which are two or three times of what is usually taken,
9 that then it does do harm. The same is true of
10 alcohol, of course. A glass of wine isn't harmful, but
11 ten or twelve glasses are.

12 What kind of harm would
13 you accept? Suppose it is shown that it is somewhat
14 less harmful than alcohol, about half as harmful
15 as alcohol. Would you accept that for legalization,
16 then?

17 MRS. TURBITT: I would think
18 so, at this time. This is off the top of my head, but
19 the feeling I have is, a person who takes alcohol
20 knows exactly what can happen. He can become an
21 alcoholic and become a social problem. He can also
22 get cirrhosis of the liver. He knows exactly what his
23 decision is entailing, and he makes that decision. I
24 think the same right should be given to these young
25 people when they know what they are making their
26 decision on, and at this time I don't think it is
27 available to them.

28 THE PUBLIC: Just to
29 interrupt, I think they realize at least that it is a
30 drug and that any drug is a crutch and they aren't
getting into something good. If I broke my leg, I

1 would want a crutch, but as soon as the leg is healed
2 I don't want it any more, and I think if people are
3 being honest with themselves, they can recognize the
4 dangers of the drug right now. I do feel that too
5 many people don't know the true dangers of marijuana.
6 However, on the other hand there are so many people
7 who are screaming and yelling against it, that you are
8 getting this reaction situation, and they are rebelling
9 and there is no point in this going on. So I think
10 that people do realize the danger if they are being
11 honest, and that is all we can ever hope for. So that
12 any more studies, although necessary, are not needed
13 for, I think, at least repealing the law for the
14 present.

15 MR. CAMPBELL: What do you
16 say are the principal dangers of marijuana?

17 THE PUBLIC: Becoming
18 something like a Soma you know, people are going to
19 take it and it is a nice tranquillizing --- no matter
20 where you are, no matter how bad the situation is
21 really, you can come down to a nice level where
22 everything is nice and groovy and, you know, a lot of
23 people do it, they do television, I mean they go home
24 and they put on the set and the set just massages them,
25 they don't have to think any more, they don't have to
26 be concerned about Viet Nam or the riots or their own
27 stupid little kids or anything, it is just this stupid
28 little show going on and on and on, and it is the same
29 thing I think with marijuana, if you are not watching
30 yourself, you are going to be doing the same thing.

1 THE CHAIPMAN: Do you regard
2 that as a harmful thing?

3 THE PUBLIC: Definitely;
4 definitely. I think if the individual is not
5 responsible to himself and is not being honest with
6 himself, then he is harming himself.

7 MR. STEIN: But you don't
8 think the law should be involved in trying to deal
9 with this; is that your point?

10 THE PUBLIC: No, I don't
11 it can. If it was feasible, I think yes, but I don't
12 think it is feasible. I think it has managed to prove
13 once again that the law is an ass.

14 THE CHAIRMAN: Gentleman at
15 the microphone?

16 THE PUBLIC: Yes. The lady
17 mentioned a brief from the Alcohol Addiction and Drug Research
18 Foundation. I have no knowledge of the brief, but I
19 have read literature of the Foundation and I have heard
20 speakers at the Foundation, and one speaker in particular
21 who I went, in my ignorance, to hear and form an opinion
22 on a very topical issue, was introduced and his qualifi-
23 cations were a degree in Business Administration, and
24 nine years of experience in a managerial capacity with
25 the International Harvester here in Hamilton. Now, I
26 hardly considered this informed opinion on something
27 that is entirely out of the business --- you know,
28 out of the scope of the business education. One other
29 thing, with regard to the Association, I know that they
30 are a very well meaning organization, but they are not

1 exposed to what could be called cross-sectional
2 statistics. They see only that, in the course of their
3 duties as an organization, they see only that spectrum
4 or that section of the drug subculture that has managed
5 to have problems with controlling their drug use. Now,
6 how about all of the people who are not having problems
7 with drugs? Similarly, an analogous situation would
8 be for someone to form an opinion on alcohol by walking
9 into the psychiatric treatment ward at the Ontario
10 Hospital here in Hamilton and seeing those who have
11 been unable to control their alcohol consumption, and
12 on the basis of this, decide that alcohol is --- should
13 be not made legal.

14 MRS. BEATTIE: I would just
15 be interested in what authority --- what responsible
16 and representative authority in writing you would
17 accept?

18 THE PUBLIC: I would accept
19 opinions of people who have been engaged in cross-
20 sectional studies of over --- cross-sectional and long-
21 itudinal studies, and who have efficiency in the
22 discipline in which they are using to focus on the
23 situation.

24 MRS. BEATTIE: And do you
25 feel these exist now?

26 THE PUBLIC: Yes, I do,
27 but I feel they are being sadly ignored by the public
28 at large.

29 MRS. BEATTIE: Could you
30 cite one?

1 THE PUBLIC: Well, I would
2 cite the collection of evidence that is presented by
3 Whittaker that I referred to before, I think, this is if
4 you want to go and look at both sides of the coin,
5 the pros and the cons, the good research and the invalid
6 research, it is all present in that book.

7 THE PUBLIC: I think it is
8 rather obvious right now that the biggest problem about
9 the drug problem is the ignorance of the people, and
10 that is that not too many people know too much about
11 drugs, and right now, you know, just because you
12 people are all here proves that you are all interested
13 and I feel this is the only way we are ever going to
14 have any accomplishment in the drug problem is to
15 educate the people more. And for those of you who
16 don't subscribe to the Addiction Foundation magazine,
17 it comes out four times a year and it is free, all you
18 have to do is send in your name. I have been getting
19 it for a couple of years and I have known of it ever
20 since I started smoking dope and I knew what I was
21 getting into and I think anyone who is ever interested
22 in any sort of addiction, all you have to do is send
23 in your name, they will send it to you four times a year,
24 and it is worth it. I have already read the preliminary
25 brief from the LeDain Commission and I understand what
26 they are trying to do, and I understand the problems
27 they have, and I recommend it to everybody.

28 MR. STEIN: You mean
29 the LeDain Commission, don't you?

30 THE PUBLIC: Yes.

1 THE PUBLIC: Am I correct
2 in assuming that you do not advocate imprisonment for
3 people who have dope in their possession, marijuana in
4 their possession?

5 MRS. TURBITT: That isn't
6 what I said. I read recently where they are considering
7 one week imprisonment.

8 THE PUBLIC: One week.
9 Would that entail a criminal record then which would
10 follow?

11 MRS. TURBITT: I would hope
12 not.

13 THE CHAIRMAN: Excuse me,
14 yes, I just wanted to be clear myself in that, in
15 recommending that this be based exclusively under
16 Provincial jurisdiction you contemplate the possibility
17 of imprisonment for possession, simple possession?

18 MRS. TURBITT: Possibly, I
19 have stated they make marijuana laws covering this.

20 THE CHAIRMAN: But it is,
21 what kind of laws, we are interested in; what we
22 are really trying to determine is what you have in
23 mind in the transfer to Provincial jurisdiction. I
24 understand one thing, ^{that} it will not be a criminal
25 offense, but does it go beyond that? Do you have in
26 mind anything about the penalties? I am just following
27 up this gentleman's question.

28 MRS. TURBITT: Not as a
29 group we didn't and this one week think I just read ---
30 I mean nobody makes a law like that. Legislation takes

1 a long time. But just when I read this law, it
2 didn't repulse me. I thought "Well, one week, this
3 I could see", but could they have a law, I don't
4 know whether they could even have a law with a young
5 person as a first offender, could they sentence to a
6 week and not have a record.

7 THE PUBLIC: How about a
8 second offender? If a person is under--especially
9 if he isn't going to school, all he is doing is smoking
10 his dope, if he can go to jail for one week and come
11 out and be free to do the same thing again, and be
12 free to go back, how long will this go on? Will this
13 be for a great period of time or what?

14 MRS. TURBITT: This is for
15 the law makers. These young people who came to us
16 and said, as an experimenter they have ended up with
17 criminal offenses, which we think is not a good thing,
18 and the laws, they should have marijuana laws thought
19 through very carefully and weighted and the amount of
20 damage to society, to the offender, all kinds of
21 things should be weighed before and offense is
22 mentioned.

23 THE PUBLIC: One other point
24 then, you have been telling us, and one of the
25 gentlemen, over there said we have been waiting 3,000
26 years and you say we should continue to wait, and that
27 if over the course of the next few years you are
28 able--or someone is able to prove to you that
29 marijuana is not harmful, then you will agree to its
30 legalization. What happens between now, and say, the

1 next ten years, what happens to the people who have
2 been convicted of any offenses; where do they go? Or
3 is your committee and the LeDain Committee willing to
4 take the responsibility for screwing up those people's
5 lives over the next ten years if they are in fact caught
6 and put away?

7 MRS. TURBITT: I would hope this
8 would be wiped out, but if you are asking me would I
9 take the responsibility, yes, if it would mean that
10 thousands of other lives would not be screwed up.

11 THE PUBLIC: Very well.

12 THE PUBLIC: Like we were
13 talking about just now between these two people, I am
14 in the same position that you were talking about, I
15 just got arrested three weeks ago for this same sort
16 of thing, and two years ago I got arrested for the same
17 thing again, mainly because I believe in it and I
18 continue, I may not do it now, but I wouldn't say if I
19 was, you know; but nevertheless I feel like a responsible
20 citizen in society, I have been working, I pay taxes,
21 I don't get into any trouble, besides at night I like
22 to sit down with my friends and smoke a few J's which
23 is as far as I am concerned, not a very criminal type
24 act.

25 Why should I be, you know,
26 my name be bastardized, so to speak, because of the fact
27 that I am doing a rather social type thing with other
28 people?

29 MRS. TURBITT: Well, as it
30 is now, it is against the law, the man might have a

1 fight with his wife, push her through the picture window,
2 knock her downstairs and be arrested. He may think that
3 she deserved it, and you feel you have a right to do
4 what you want to do as he may feel he had the right to
5 push her out the window, but it is against the law, and
6 we can't change the law because individuals want special
7 privileges.

8 THE PUBLIC: No, no, no, no,
9 I
no. It is against the law and will go along with that
10 to a certain degree, except, if they do legalize it, in
11 other words it has been all right all along. So how
12 can you consider something was against the law then,
13 but it was through our stupidity that it was against
14 the law.

15 MRS. TURBITT: Okay,
16 stupidity or ignorance, we don't know.

17 THE PUBLIC: Okay, but in
18 the meantime, my court case is coming up; what am I
19 going to do if I get sent away to jail?

20 MRS. TURBITT: But you made
21 this decision.

22 THE PUBLIC: I made this
23 decision?

24 MRS. TURBITT: You knew ---
25 this is what I am saying.

26 THE PUBLIC: Is it a good
27 law?

28 MRS. TURBITT: I am not
29 saying it is a good law, I am saying let us examine it
30 and see if it is a bad law. We have a whole book full

1 of bad laws.

2 THE PUBLIC: That is what
3 I am saying too; let us examine it. You know, let us
4 really examine it, but people have been putting it off,
5 not just to-day or yesterday. It has been put off for
6 over a quarter of a century.

7 MRS. TURBITT: I don't think
8 it is being put off now, or this Commission would not
9 be here.

10 THE PUBLIC: All right,
11 thank you.

12 THE PUBLIC: Mrs. Turbitt,
13 I would like to ask you --- you mentioned about going to
14 jail as being one of the means --- like a short term ---
15 well just a way of making these people realize that they
16 are doing something wrong. Well, what do you hope to
17 prove by sending a person to jail? Do you know what the
18 inside of a jail is like to begin with?

19 MRS. TURBITT: I have been
20 through them, but not on the wrong side.

21 THE PUBLIC: Okay, so you
22 have seen what it is like, it is a small confined space
23 and you are not allowed too much room, but what are you
24 trying to prove by sending a person for a week?

25 MRS. CHERNENKO: But don't
26 you feel that sending them to jail for a week, if this
27 happens, if this takes place and they change the law to
28 this extent, that we only send them to jail for a week,
29 it's a heck of a lot better than having a great big
30 criminal record and going to jail anyhow, plus paying a

1 nice big fine?

2 THE PUBLIC: Well, I don't
3 see any sense in doing either. I don't see any sense
4 in sending people to jail.

5 MRS. CHERNENKO: Don't you
6 think the one is better --- it is better by doing this,
7 that you are not going to go away to jail for seven
8 months?

9 THE PUBLIC: Okay, in that
10 light itself, but I think there should be --- like
11 jail is kind of out of the question for something as
12 small as marijuana.

13 MRS. CHERNENKO: But you are
14 still breaking the law. There has to be some deterrent
15 there for you people when you are breaking the law.

16 THE PUBLIC: But the thing
17 is like, it is not that you are --- if it was changed,
18 if the law was changed that it was legal, I think this
19 would be a much better suggestion than just lowering
20 it to one week. Because if you are going to smoke
21 marijuana, you are probably going to smoke it after
22 you get out of jail, you will continue smoking it if
23 you really feel that strongly about it. So I can see
24 no sense in continually sending people to jail, time and
25 time again, either now when the laws are heavy when you
26 go to jail for two months for your/^{first} offense or you get
27 a heavy fine, or for a second or third offense you can
28 go like from two to ten years, I understand.

29 MRS. CHERNENKO: You tell
30 me what you would suggest be done with these people, then?

1 THE PUBLIC: I suggest you
2 don't do anything with them.

3 MRS. CHERNENKO: There has to
4 be something done when you are doing something illegal
5 and breaking the law; there has to be something done,
6 right? There is no way you can argue that, there has to
7 be something done.

8 THE PUBLIC: Sure, there has
9 to be something done, but just like going --- being
10 arrested in itself, is doing something. Being
11 arrested and spending a night in jail, whatever you are
12 doing.

13 MRS. CHERNENKO: But is not
14 one week better than two months or seven years?

15 THE PUBLIC: Right, but that is
16 ^{not} what I'm saying I don't see any sense at all in
17 sending people to jail. Like you kind of agree with the
18 one week thing, but I say that we totally abolish the
19 law.

20 MRS. CHERNENKO: I agree
21 with the one week thing if it is going to put a
22 deterrent on it now, because it is still illegal, but
23 I don't agree with what they are doing now by taking
24 you kids in and giving you the identification, putting
25 you through all that, and then you go up on a summary
26 conviction, and you still have a criminal record. I am
27 with you kids on that fact. But I still feel that there
28 has to be some deterrent because you are doing something
29 illegal at this time.

30 THE PUBLIC: Excuse me.

1 There is one thing that you are really overlooking. That
2 as soon as you are picked up by the police and you are
3 processed and you go into court and you are convicted,
4 that is the only way you can go into jail. They don't
5 send you there for summer camp. That is the only way
6 you can go there, is to be convicted. Now whether it
7 is one week or two weeks or three months, that is a scar.
8 one week
8 This/stuff, no way, please. Say the guy is working, what
9 is he going to say to the boss? "Gotta take a week's
10 vacation, gotta go to jail." He is not going to have a
11 job now when he comes back. If people are just going
12 to jail overnight and their employer finds out, they
13 do not have a job.

14 MRS. CHERNENKO: This is what
15 we are saying, it is your choice. If you get caught,
16 somebody has got to pay the musician.

17 THE PUBLIC: It is not our
18 choice; it is your mistake and the law.

19 MRS. CHERNENKO: But this is
20 what we are trying to tell you, we are trying to help
21 by correcting the law. We are trying to help you, not
22 hurt you.

23 THE PUBLIC: Great, then
24 don't talk about jail at all. It is no rehabilitation.

25 MRS. CHERNENKO: But this is
26 is.
26 the way the law/ There is nothing we can do about it.

27 THE PUBLIC: Fine, but we
28 cannot ---

29 MRS. CHERNENKO: But look,
30 we are just a small minority group. If you people don't

1 | come forth and give us information, too, which would be
2 | a great help, you know, because you stand up and say
3 | that what we have got is all wrong, is all hogwash and
4 | this, but I don't see any of you kids sitting down and
5 | writing letters to your editors or anything like this
6 | to give the adult population the information that you
7 | have that you think is correct. It might very well be
8 | correct.

9 | THE PUBLIC: There is one
10 | big problem there and I think most of the kids will
11 | agree.

12 | MRS. CHERNENKO: Communication.

13 | THE PUBLIC: Not even
14 | communication. It is the fact that if he could get up,
15 | he wouldn't before the LeDain Commission or before ---
16 | I was sent on a panel a little while ago back in
17 | November in Ancaster and we were talking about marijuana.
18 | But the place was full of police. Now as soon as you
19 | are talking of being in favour of marijuana, you are
20 | looked at by authorities. Now maybe this is just a
21 | paranoia but it is a paranoia held by just about every
22 | person who smokes marijuana, and you can't get away
23 | from it. Now I realize you only had a week to get your
24 | paper ready, or whatever time it was, it was quick time.
25 | Now, I, myself, of course don't know anything about your
26 | Committee or Council but I did not see anything in the
27 | papers, I heard nothing about what you were doing. Now
28 | I assume you must have talked to some young people, but
29 | talking to the people in High C or (inaudible) or
30 | Christian Youth, well they don't know where it is at.

1 MRS. CHEPENENKO: No that is
2 not the people I talked to.

3 THE PUBLIC: That is good.

4 THE PUBLIC: If I may make
5 a comment or two here. I think that the basic problem,
6 in my own personal opinion, is that although this
7 Commission is into the non-medical use of drugs, what you
8 really should be considering is turning this non-medical
9 use into a medical use. Because what we are facing here,
10 in my estimation, is a medical problem, a social-medical
11 problem. I think that the only way it can be properly
12 met is on the basis of treating it as a medical problem
13 and treating it through proper facilities like hospitals.
14 And I suggest that the ^{example} that has been set to us by
15 England be very carefully analyzed, and thoughtfully
16 contemplated in use in Canada. I don't like to see us
17 getting into the position as in the United States. I
18 don't think it is a police problem; I think it is a
19 medical problem; I think it should be treated medically.
20 The young people who feel they need a drug to escape
21 from society, it is a medical reason. They need
22 psychiatrists, social workers, they do not need policemen.
23 I think it is a problem that is not going to be solved
24 by police or by professional investigators. It is going
25 to be solved only by analyzing what the need is for
26 these young people who take these drugs. They are
27 obviously taking them for a reason, whether it is society,
28 whether it is their own lack of ability to meet society.
29 These are questions that have to be met by the people
30 themselves, and one of the young people mentioned this

1 when I came in. But I think the way that this has to
2 be handled is through hospitals. I think that the
3 drug should be available to people who want it on
4 demand at hospitals. I think it should be supervised
5 by physicians, social workers and psychologists and
6 psychiatrists. It should be a team effort. I should
7 think it would be an extensive effort on the part of
8 society to find out why our young people, who are
9 distressed, are copping out. And I don't think it will
10 be solved by talking from a legalistic point of view.
11 I think it must be attacked from a compassionate point
12 of view, from a problem point of view. I think the
13 only way it can be solved is this way

14 MR. CAMPBELL: When you say
15 it is a medical problem, could you clarify what you
16 see as the problem? I take it, by implication from
17 what you said, that a person who is using the drug
18 has a problem that is amenable to medical treatment and
19 should be treated in that way. Am I interpreting you
20 correctly?

21 THE PUBLIC: Yes, you are.

22 MR. CAMPBELL: If we were to
23 assume that, well, something in excess of 20% of
24 University students--to make a rather conservative
25 statement--have used cannabis, 10% or more high
26 school students, are you suggesting the fact that that
27 number of people should be given rather close medical
28 attention?

29 THE PUBLIC: I do.

30 MR. CAMPBELL: What about

1 the adult population who are using alcohol as a drug?

2 Would you include them in the same way?

3 THE PUBLIC: Yes.

4 MR. CAMPBELL: You make this
5 statement as generally about the alcohol user as the
6 cannabis user, that anyone using alcohol has a problem
7 that should be treated medically?

8 THE PUBLIC: Well, I frankly feel
9 that there is a strong sensibleness in that statement.
10 However, society has accepted this drug for centuries,
11 and our culture accepts this drug. Therefore, it is being
12 used to the vast majority of the population, sensibly.
13 There are 4% I believe, of drinkers who become alcoholics.
14 Now that is bad enough, but I think like --- as the lady
15 on the Committee pointed out, when you step into this
16 role of becoming an imbiber, you therefore know --- you
17 know all about the side effects, and you know about the
18 dangers. I don't think anybody in this room really knows
19 about the dangers of marijuana, and nobody has brought
20 up the fact that obviously if you are smoking this drug
21 you are going to have cancer. I think it is a reasonable
22 assumption to make. I think if you can smoke one leaf
23 or another, it is going to produce some type of cancer
24 in the lung, and I don't think that is an unreasonable
25 thing to say.

26 MR. CAMPBELL: Now when you
27 suggest that giving medical treatment to all people
28 using cannabis, where would you put this in your scale
29 of social priorities? Of any of the estimates that have
30 been made about the number of people using cannabis, this

1 would require, certainly, a very heavy monetary outlay.
2 It would also require a commitment to a lot of extremely
3 highly trained people who are in rather short supply.
4 Would you give this level of priority ---

5 THE PUBLIC: I certainly
6 would and I can't see why we should even debate it, because
7 these people are our future --- these people are what
8 are going to make our society run, these are the taxpayers
9 and the parents of the future, these are the people who
10 will be our society. We have no choice. The cost of
11 policing the thing is going to be fantastic. It won't
12 work. You are absolutely right, it won't work. It
13 hasn't worked in the States. Across the border, you can
14 see the mess they are in and you are talking about
15 marijuana, per se, but there is a big other drug problem
16 here that is lurking around the corner, and policing
17 doesn't work.

18 MR. STEIN: What if
19 people, on the same subject, are not interested in
20 receiving this treatment?

21 THE PUBLIC: That is the
22 nub. To get the drug, they must come for the treatment.
23 They must come to a hospital centre. For example in
24 Hamilton, I can envisage about five centres. That is
25 the only places drugs are available, they are available
26 free. There is no profit motive, but it is only
27 supplied in a legal manner at these sites, and it is
28 only supplied at the site and it is only available to
29 be used at the site. Take the black magic out of it,
30 and take all the social implications out of it, and

1 then you get down to the nitty-gritt, the fact that
2 this man is trying to escape or this man is trying to
3 avoid an issue, and also, I might add, you get some
4 very valuable data because you have got all this
5 information available to you because they are coming
6 to the centre.

7 MRS. WASS: Excuse me,
8 which drug are you talking about?

9 THE PUBLIC: I am talking
10 about any drug, I am talking about any drug anybody
11 wants.

12 MRS. WASS: I mean, you
13 could even have free booze, and come there and get a
14 bottle, as well?

15 THE PUBLIC: I would prefer
16 that than seeing a whole family going to it.

17 MRS. WASS: It would be
18 rather expensive.

19 THE PUBLIC: I don't think
20 if you looked at it realistically, that it's any more
21 expensive than alternate methods.

22 THE PUBLIC: I would ask
23 you if you honestly believe the people who smoke dope
24 now, who go to the hospital to smoke it, you would have
25 an underground, you would have a black market, the same
26 way you have it now.

27 THE PUBLIC: I realize you
28 would probably have this and I think that this is the
29 reason why you have the law modified, but you leave
30 the law in to a lesser degree so that people who are

1 going to use this drug outside of the framework of
2 the society's availability face the consequences. You
3 have raised the issue with the Committee here. You
4 said the law is an ass. I say the law could be changed
5 so that anybody that wants to have the drug can stay
6 within the framework of the law, the law is available
7 to him. But if you want to stay out of the framework
8 of the law and have this drug, if you want to have your
9 little subculture, if you want to have your escapism,
10 then you face the consequences because it is not a
11 drug that you are doing, it is not a drug that you are
12 taking, you are just turning your back on society and
13 your role in it.

14 THE CHAIRMAN: I think that
15 Mrs. Turbitt and ladies, I think you have been at that
16 table for quite a long time and you have been of great
17 assistance and I should release you.

18 Thank you very much for your
19 help.

20 Thank you.

21 I call now --- and I don't
22 mean to interrupt anybody at a microphone, but I
23 would just like to announce the next submission. I
24 call now on Mr. Art Buckley of the Hamilton Y.M.C.A.

25 Mr. Buckley is chairman
26 of the Committee on Youthful Drug Abuse as well, and
27 General Secretary of the Y.M.C.A. in Hamilton. Would
28 you like to be seated at the table, Mr. Buckley?

29 Gentleman at the microphone?

30 THE PUBLIC: I believe the

1 gentleman who was just on had made on a great mistake,
2 and that is assuming anyone who takes a drug has a
3 problem. I think we have socially accepted alcohol as
4 long as it is used moderately as not being a problem
5 drug, and I similarly accept marijuana in the same respect
6 However, the misuse of drugs which I consider such people
7 as speed freaks or acid heads, people who are clearly
8 in danger, are people to worry about. You are not going
9 to change our technological society by disallowing us
10 any relaxation at all, and I think this is what this
11 gentleman is trying to say. He wants us to stop drinking,
12 and stop smoking, and stop all forms of relaxation. I
13 just don't think it is possible in this society. I think
14 we should concentrate our efforts more on the drug abuse
15 rather than on all sorts of drug use.

16 THE CHAIRMAN: Mr. Buckley?

17 MR. BUCKLEY: Mr. Commissioner,
18 I don't have a brief because I was only asked yesterday
19 to appear, because your Committee had heard about our
20 organization here in Hamilton called Committee on
21 Youthful Drug Abuse which is a body of the Addiction
22 Research Foundation of which I happen to be a volunteer
23 board member, and this, I think, particular Committee,
24 I gather,^{is} unique in the fact that it represents a very
25 wide spectrum of people and organizations in the
26 community who are interested in the drug problem. It
27 was organized really, I think, because we don't believe
28 that anybody really knows what the drug problem in our
29 community is or what it's extent is, and in drugs we
30 call alcohol a drug from our point of view.

1 Secondly, everybody in the
2 community seemed to be getting on the so-called drug
3 band wagon about--everybody was having a seminar
4 drugs and everybody was talking about it, and parents
5 were unhappy it, and the kids were unhappy about what
6 the community felt about it, and so we thought we had
7 better try and find out what was really happening and
8 could there be any kind of sensible coordination? We
9 also knew that a lot of kids who had drug hang-ups were
10 not using the medical facilities available in the
11 community.

12 Thirdly, we knew that a lot
13 of parents were concerned about what was happening to
14 their kids, but didn't know where to go and go about
15 as much misinformation as good information, and
16 lastly, that we recognize that this is a total community
17 problem. There is no one group or no one organization
18 or no one service that can resolve the drug problem,
19 if there is such, and we believe there is a drug problem
20 including alcohol. So we thought we would just pull
21 some key people together in the community to look at it.
22 And I will give you a kind of a run down on the kind of
23 people--there were a couple of medical doctors from
24 the McMaster Medical School; there were three students
25 from McMaster, all of whom had been at one point drug
26 users, whether they still were or not we don't know as
27 we didn't ask them this. There was the head of a
28 community survey and a volunteer man from Burlington
29 the Research Director of the Social Planning Council
30 the Chairman of the Hamilton Academy of Medicine, the

1 Chairman of the Hamilton --- I could never pronounce
2 this word properly --- Pharmaceutical Association. There
3 was the head --- volunteer head of the Kiwanis Drug Alert
4 there were three drop-in centre operators, all of whom
5 had dealt with drug problems, and there were two
6 policemen. And I think our first meeting was a very
7 violent confrontation between the kids from McMaster
8 University and the police as to whose function was such.
9 I won't go into a long detail on this whole business and in
10 the course of three or four meetings, I think what has
11 happened is that, number one, the police have a much
12 better understanding of how the kids who get picked up
13 feel about the current drug laws, which certainly the
14 kids think are wrong. Secondly, that I think the police
15 --- that our feeling, as a Committee, is that a lot of
16 kids that get picked up, get picked up because, to use
17 their own jargon, they want to get busted. Not because
18 somebody chased them.

19 We think that thirdly, we are
20 now currently working on a system which we hope will be
21 helpful. We discovered, for example, that a lot of the
22 kids that had bad trips would go on a Friday or a
23 Saturday to a local emergency ward of a hospital
24 and they would bump into some poor doctor who had just
25 sewed up somebody from an automobile accident, or just
26 helped some mother with a child who had fallen down the
27 stairs, and here was a kooked up kid who had really
28 created his own problem, and therefore the kids felt
29 that the doctors treated them like dirt, because of this
30 kind of a feeling and so they were not using the medical

1 facilities that were available for this kind of treatment
2 in the community. And so it is some very interesting
3 discussions have gone on in our community with some of
4 the drug addiction people, some of the medical people,
5 some of the hospital people, some from the Academy of
6 Medicine trying to sweat this one out.

7 I think also in this
8 community, now, that we hope to experiment this summer ---
9 we think we have got the money; we are not sure yet;
10 in terms of half a dozen University students, all of
11 whom are part of the drug culture, working on a telephone
12 answering service twenty-four hours a day, based on
13 a Boston kind of plan in which we hope to find out
14 really what is the drug problem in a community like ours.
15 We don't really know. We know a lot of kids say they
16 take drugs, don't take them, because it is the thing
17 to do. We know a lot of kids who take them don't admit
18 it. We have talked with a lot of kids on speed and
19 LSD and they are, I think, a pretty confused lot. But
20 I think what we are really trying to say is, that the
21 drug problem, and it is a problem in our community to
22 parents, to kids, to the police, to the hospitals, it
23 is a total community problem and we are only going to
24 make any kind of successful attack on this problem by
25 working as a total community, and nobody can do it on
26 the basis --- I think that is all I need to say, I want
27 to say. I would be happy to try and ^{answer} any questions.

28 MR. STEIN: I have one
29 question, regarding the belief or feeling your Committee
30 has in young people who are arrested, being those who

1 want to be arrested echoes something that was said
2 earlier this morning by the doctor who was here. And I
3 am interested in the basis for this observation. What
4 leads you to that conclusion?

5 MR. BUCKLEY: I think only
6 some conferences with kids and what not to our --- we
7 only have feelings about this and only gossip information,
8 I can't document it in any way, shape or form. I think
9 we are saying that the police in our community, in our
10 opinion do not go looking for users of marijuana.

11 MR. STEIN: There are no
12 undercover operations?

13 MR. BUCKLEY: There are no
14 undercover operators to our knowledge. I am talking
15 for the users of marijuana. I am saying to our knowledge.
16 That doesn't say they don't exist. Of course I do know
17 in a session --- I worked with eight kids who were on
18 speed one night and they thought there was a narc behind
19 every lamp post, was their feeling. But to our knowledge,
20 there aren't-- and the average kid who gets picked
21 up, unless there is a wild party or some kind of a bash,
22 or somebody squeals, -who gets picked up for possession
23 of marijuana, usually asks for it.

24 MR. STEIN: Perhaps this is
25 an unfair question and if you can't answer it, fine.
26 I wonder if there was any representation made to you
27 where in your communication with law enforcement, that
28 was directed to this question. In other words, did you
29 have the impression that law enforcement in this local
30 area are not actively interested in pursuing possession

1 offenses, or was this based at all on conversations?

2 MR. BUCKLEY: This would be
3 my feeling.

4 MR. STEIN: Based on your
5 conversations with law enforcement people?

6 MR. BUCKLEY: Based on
7 conversation with people who probably talked of law
8 enforcement.

9 MR. STEIN: I see.

10 THE CHAIRMAN: What is the
11 relationship of your Committee, Mr. Buckley, to the
12 Peel County Task Force on drugs? Is there any
13 connection?

14 MR. BUCKLEY: Is that the
15 one Dr. Anderson is involved in?

16 THE CHAIRMAN: No, Father
17 LeBlanc.

18 MR. BUCKLEY: No, our ---

19 THE CHAIRMAN: There is no
20 connection?

21 MR. BUCKLEY: No, there is
22 no connection.

23 DR. LEHMANN: How would
24 you explain --- well, we heard from two young men in
25 the audience to-day that they had been busted and
26 would you assume they, in a way, wanted to?

27 MR. BUCKLEY: I don't know.
28 I think one of the basic problems, and I think I heard
29 some of this earlier, was that there was so much
30 misinformation about drugs and I think we of the adult

1 community, in the beginning certainly lied to a lot of
2 kids about marijuana. There was a lot of false
3 information, and therefore I think there was a
4 tremendous credibility gap. I don't know whether that
5 information is true or untrue, but all I know is that
6 the information we get back is that most of the kids
7 that get picked up for possession of marijuana, tend
8 to look to be picked up, ^{are} or/in some kind of unusual
9 circumstances.

10 DR. LEHMANN: Who gives
11 you this information?

12 MR. BUCKLEY: I have
13 gotten it from about four kids, from some informal
14 discussion with some unquotable police officers. You
15 know, you couldn't say who they were. And I have
16 gotten it from some drop-in centre directors.

17 THE PUBLIC: I could quote
18 the head man of the R.C.M.P. Narcotics Bureau,
19 Corporal (Crystall), told me in June of last year that
20 he did not subscribe to the theory --- are you familiar
21 --- you know who Corporal Crystall is --- he did not
22 subscribe to the theory that not prosecuting the
23 small --- he felt that the more small people that he
24 got that were prosecuted, the more offenders that were
25 nailed for possession, he felt this would instill a
26 scare and I would quote that to his face because he said
27 that to me over ^{a desk} / that he subscribed to the theory that
28 ^{he knew} anyone/who was in possession, if it was just a girl
29 who smoked one joint in her whole lifetime, he would
30 go up to her house and he would go in the door and

1 search her whole house top to bottom because he felt
2 that the more people that got it, the more people who
3 were arrested, the more the scare would sort of go in,
4 now whether he has changed his policy since possibly
5 June 22nd of last year to today, I don't know, sir.

6 MR. BUCKLEY: Well my
7 information is only the local police force.

8 THE PUBLIC: Yes, and also
9 in my experience with people that have been arrested,
10 I would say indisputably, the majority of offenses that
11 are sort of report are through informers, not the idea
12 of an R.C.M.P. officer growing his hair long and going
13 into a school, because generally they would be laughed
14 out. It is members of our own peer group that
15 generally take it upon themselves through what seems to
16 us a feeling of moral self righteousness, but they may
17 be motivated by other considerations ---

18 MR. BUCKLEY: What do you
19 mean, are you talking about the R.C.M.P.?

20 THE PUBLIC: No, I'm talking
21 about the people in our own peer group that report to
22 the R.C.M.P. offenders and suspected offenders. I know
23 people that don't even smoke marijuana that have had
24 their houses searched, obviously on some kind of a tip.
25 So I really consider that is the major source of their
26 information as far as arresting people. I don't
27 consider they have all-night stake-outs trying to get
28 a kid with a nickle of weed, you know.

29 THE CHAIRMAN: Thank you
30 very much, Mr. Buckley.

1 We call now upon Mr. Robert
2 H. Brand.

3 Mr. Brand?

4 MR. BRAND: I would like to
5 state that this is my own opinion; I do not represent
6 any group whatsoever. I am speaking here simply as a
7 father and a man of the older generation. I have this
8 letter addressed to Mr. Moore, Metcalfe Street, Ottawa,
9 as requested in the ad that I saw two
10 days ago in the Hamilton Spectator.

11 "Dear Mr. Moore: With the
12 creation of this Commission,
13 this Government has proven
14 itself once again unfit to
15 govern. The day will come
16 when the present administration
17 will be cursed by the children
18 of to-day's misbegotten
19 results of five minutes
20 pleasure. This is not to be
21 read as an insult to you or
22 your members. You too have
23 fallen victims of to-day's
24 permissive way of life. After
25 the war, if you remember, there
26 came out of the melting pot
27 to the south of us a woman who
28 advocated that to stop further
29 aggression by the German people,
30 to teach their children dis-

1 obedience. Never, in the
2 history of the peoples of
3 this earth, has any genera-
4 tion taken anything to heart
5 as this misguided, even crimi-
6 nal, slogan."

7 THE CHAIRMAN: Who was that?

8 MR. BRAND: I am very sorry,
9 I cannot recall the name of the lady. She was apparently
10 or reportedly a psychologist from the United States. I
11 am sure somebody will be able to find out who it was.

12 DR. LEHMANN: Was it an
13 anthropologist or a psychologist?

14 MR. BRAND: What I remember,
15 and this is going back twenty-five years, I think she
16 was called a psychologist. I think it was at the time
17 at the end of the war just about before or during the
18 beginning of the Marshall Plan.

19 "Without going further into
20 the history of this incon-
21 ceived advice, I would like
22 to point out to you and all
23 of those who may be looking
24 for a reason why it is
25 necessary to call a Commission
26 like yours into being the
27 result of that message surely
28 must have been harboured (by
29 your people or a relative of
30 yours). To have in this day

of lunar flights,
of unprecedented technicol-
ogical advance, in this age
when we can almost create a
new human being from an old
one through transplants, etc.,
to bow to the demented demands
of this/sick/section of society,
only proves that maybe Einstein
was right when he said that
the next war but one will be
fought with bow and arrow.
Instead of wasting the
energies and intelligence of
the people involved in this
inquiry, would it not be so
much better to use these
same qualities to try and
undo the harm that has been
done since the end of the
last war, by taking a
positive approach to the
whole question of juvenile
delinquency and the way that
the future of the world is
being jeopardized by the
constant appeasement of those
under thirty. Is it so
important for members of
Government to always be

doing the popular thing, to
be sure to get enough votes
the next time? It seems
strange that the same man
who is so set against smoking,
should be instrumental in
calling this committee into
being.

Governments and people have
finally realized that the
discriminate pollution of
our air and water is becoming
dangerous and has to be
curtailed and stopped altogether.

Would you not then say that
the pollution of the present
generation is so much more
dangerous and that ways and
laws have to be found and
passed to assure future
generations of a healthy,
and normal life, whether it
be here on earth or somewhere up
there amongst the stars for
which we are now reaching? It
is time you proved that you
still have some backbone left
and start going back to the
old values that prevailed
when we grew up. The

psychological balderdash with
which the young are being
coddled to-day will not bring
up the man we need to make a
better tomorrow. More trips
behind the woodshed instead
of to the couch will instill
the respect and discipline
this generation never heard of
Only then will it become possible
to undo the terrible damage
that was wrought by the sickly
mind that uttered this sentence:
"Teach them this disobedience" and
return our youth and their
parents to a sane society
where we can pursue the right
to live the way human beings
were meant to live.
In closing, I will then say
that the whole aspect of your
Committee and its inquiry, to
me, are the result of the
weak kneed administration
fostered by an indulgent
populace who seem to have lost
direction in the world to live
like men, who have come down
from the trees and have learned
to walk upright without the

1 help of crutches. I herewith
2 reject the necessity of your
3 Committee and urge the
4 Government to use its powers
5 in a way that will be con-
6 structive rather than destruc-
7 tive for the people for
8 generations to come, if by
9 some perverted twist of fate
10 this Government should legal-
11 ize the non-medical use of
12 drugs."

13 Thank you.

14 THE CHAIRMAN: Thank you,
15 Mr. Brand.

16 What kind of a policy do
17 you advocate, more specifically; what measures do you
18 advocate to achieve the purpose that you describe there?

19 MR. BRAND: It has taken
20 us twenty-five years to reach this stage and I would
21 hope it would not take us another twenty-five years to
22 return to a normal way of life, the way it was before
23 this problem arose.

24 If you would like to have ---

25 THE CHAIRMAN: Are there
26 any questions? Yes, the gentleman at the microphone?

27 THE PUBLIC: Do you have
28 any facts to back up all that balderdash?

29 MR. BRAND: I think your
30 being there is fact enough.

1 THE PUBLIC: Being where,
2 here? At least I am looking at it with an open mind and
3 willing to look at the reports that are coming out, but
4 obviously you are overlooking everything that has been
5 said about the whole thing, or is going to be said about
6 the whole thing. You have not paid attention to anything.
7 Even if the Committee is to come out with a certain
8 standing, you are not going to pay any attention to it,
9 obviously. This is where we are having trouble with
10 the society right now, this is where we are having the
11 generation gap because we are running into people who
12 are not listening / ^{we are} not asking for anything except
13 listening, just to listen.

14 MR. BRAND: I am listening;
15 I have not heard anything.

16 THE PUBLIC: It seems to me,
17 sir, that you have more sympathy with the Government
18 that could make the trains run on time, than a Government
19 for the people by the people, and the thing is that
20 this --- sir, I have no idea what your conception of
21 order is. What is your idea of order; was the Hitler
22 youth order? Was what happened in Italy and Germany and in
23 the Communist countries, was that order, is that what
24 we want, the stifling of individualism for the sake of
25 order, for the sake of not offending a few people's
26 sense of what is right or wrong?

27 MR. BRAND: Who are these
28 individuals you are talking about?

29 THE PUBLIC: Individuals. I
30 am talking about the people.

1 MR. BRAND: What people?

2 THE PUBLIC: The poor
3 people, the people like us, the students, the educated
4 people that want the right to live the way they want to
5 live without having someone elses moral code of twenty-
6 five years ago which produced something --- the worst
7 the world has ever seen, and it is not my generation.

8 MR. BRAND: What about
9 thirty years ago?

10 THE PUBLIC: It is still here
11 with us to-day and it is not my generation that started
12 it.

13 MR. BRAND: What has your
14 generation started?

15 THE PUBLIC: Lord knows, we
16 are not getting much of a chance.

17 THE PUBLIC: Sir, I feel you
18 have presented your ideals but you have not really
19 presented any ways for this Committee to act. I assume
20 that some of them or some part of this Government that
21 have had --- you have made no recommendations as to how
22 they should bring about these standards as such, and you
23 have not clarified exactly what these old standards are.
24 You have left them as ideals, and I think you should
25 clarify exactly what you mean by old standards and how
26 they should be pointed out.

27 MR. BRAND: Time is much too
28 short for me to do that, but I think I have explained
29 as well as I can in the short time available to me.

30 THE PUBLIC: You have time

1 at least now to explain.

2 MR. BRAND: No, I have not,
3 I have to be (inaudible) at five o'clock.

4 THE PUBLIC: I suggest you
5 leave then; you will not make it otherwise.

6 MR. BRAND: I know that
7 truth is not very pleasant.

8 THE PUBLIC: This is a
9 mighty important fact, can't you make the time?

10 MR. BRAND: No.

11 THE PUBLIC: You can't? In
12 other words you just don't give a damn. If you did,
13 you would stop and talk about it.

14 MR. BRAND: The fact that I
15 am here must convey some sort of idea to you that I do
16 care, otherwise I would not have taken the time to come
17 here in the first place.

18 THE PUBLIC: But nevertheless,
19 you have made a statement and you do not want to
20 clarify it. The man just asked you a question, and you
21 say you have not got the time, you have to be at the
22 west end at five o'clock.

23 MR. BRAND: You were not
24 even listening.

25 THE PUBLIC: Excuse me, sir,
26 the way the human being has developed in our evolution,
27 we were given no natural leisure time. Do you
28 also condemn the use of our planes the way you condemn
29 the use of drugs, as an unnatural act?

30 MR. BRAND: I am afraid I

1 cannot say that.

2 THE PUBLIC: That answers it.

3 THE PUBLIC: May I ask you to
4 narrow, perhaps give us a more specific idea of what you think
5 legitimate Government concern should be. You speak, you
6 say that this Commission is misguided and misfounded
7 based on poor ground, poor society.

8 MR. BRAND: I think that this
9 Commission has been created through pressure from certain
10 groups, pressure which maybe has been created by the
11 young people of this country, and I don't think the
12 Government should be pressurized by young people, who
13 have not yet opened their eyes.

14 THE PUBLIC: Sir, would you
15 not admit that the pressure is not just on the part of
16 young people. The concern now is a concern that has
17 swept the continent. It is a concern of the parents to
18 try to understand the young people. What better means
19 is there than a non-partisan Committee?

20 MR. BRAND: I would like to
21 turn that around. It is not a concern of the parents ---
22 a concern of the young people, it is the young people's
23 concern to understand their parents. When you become
24 parents, then you turn around and tell them.

25 THE PUBLIC: Aren't there
26 two sides, sir? And, sir, if the idea of a non-partisan
27 Committee, if that is not the way to solve a problem,
28 let's take the other extreme. Today's headline in the
29 newspaper says, "two more college gun deaths." That's
30 severe repression to a permissive society that you reject.

1 Do you see that as the means? Where do you lie in
2 between a fair study and political oppression?

3 MR. BRAND: Why should it
4 have come that far? What are the underlying causes that
5 these kids should be put in such a position, or should
6 place themselves in the position where they can be shot
7 at?

8 THE PUBLIC: That is a subject
9 that can be long debated, this is a study that should be
10 found out, and this is a study.

11 THE PUBLIC: Sir, where these
12 two gun deaths occurred are in Mississippi. I would like
13 you to go down to Mississippi. I have been there. I was
14 around that area. I lived in Arkansas for a long time.
15 You should go there.

16 MR. BRAND: Are you from the
17 States?

18 THE PUBLIC: I am from the
19 States.

20 MR. BRAND: May I ask you
21 what you are doing here?

22 THE PUBLIC: I am avoiding the
23 draft, and people like you ---

24 MR. BRAND: I suggest you
25 read the editorial page of today's Spectator.

26 THE PUBLIC: You will get
27 sick if you do.

28 THE PUBLIC: Sir, I have one
29 thing to say to you, although it is very hard for me to
30 say it to a person like you at all, but right-wing bigots,

1 especially people like you, just make me feel like defiantly
2 going out and smoking a joint, just lighting it.

3 MR. BRAND: I hope it makes
4 you very happy.

5 THE PUBLIC: It doesn't make
6 me happy, it makes me very hateful that you don't
7 understand anything. You think your way is the only
8 right way, you won't listen to our way. We have got
9 something to say too. We may be young, but we have got
10 something to say too.

11 THE PUBLIC: It isn't nece-
12 ssarily right though.

13 THE PUBLIC: And 50% of the
14 population is under twenty-five.

15 MRS. TURBITT: I would just
16 like to say to you young people that this man has been
17 brought up in a certain type of way; he is a victim of
18 his environment. If you grow up and have a bunch of
19 squares saying "We don't want this, we don't want that,
20 we would like/^{you}to go to church every Sunday, we would like you
21 to do all these things you people don't approve of," then
22 are you going to be willing to be attacked? You are being
23 as close minded to him as he is being to you. I am not
24 standing up for either side, I am just saying that there
25 is close mindedness in the room, and there isn't any
26 communication at all.

27 THE PUBLIC: We are not passing
28 the laws to incarcerate people.

29 THE PUBLIC: Didn't I make an
30 attempt for communication? I asked the man to narrow, to

1 | say specifically on what grounds he rejected the Commission
2 | and what he saw as the means to discuss a problem, which
3 | is very evident. And I was met with close mindedness.
4 | I was met with no answer.

5 | MRS. TURBITT: Perhaps he
6 | hasn't an answer. As he said, he just prepared this,
7 | and I know he just prepared it and brought it, just to
8 | bring his views and I think we should accept his views.
9 | We are accepting yours.

10 | THE PUBLIC: What views has
11 | he given us?

12 | MRS. TURBITT: That he
13 | doesn't approve.

14 | THE PUBLIC: If he tells us
15 | his views, he has obviously had them for thirty years,
16 | and it doesn't require half an hour to say what he had
17 | for thirty years. It didn't take him half an hour for
18 | this, and if he did, what kind of drug has he taken?

19 | THE PUBLIC: I think it is
20 | pretty hard for anybody who is brought up in a democratic
21 | society to understand facism and dictatorship, which seems
22 | to be the way this gentleman was brought up. I for one
23 | can't understand it, how he says, "You do it, get some
24 | backbone, and we don't care what you say, you do it my
25 | way". We are not saying it that way here, we are
26 | asking, we are asking to legalize marijuana, let us do
27 | our own thing, and don't worry about us. We know what
28 | we are doing, but you people don't.

29 | MRS. TURBITT: We are trying
30 | to find out, sir.

1 THE PUBLIC: Why?

2 THE PUBLIC: The only person
3 that will listen to a person about marijuana, a legitimate
4 statement, is someone who has done it, someone who has
5 tried it; then they know what they are talking about.
6 Someone, you can explain and talk to people about as long
7 as you want to, what a marijuana high is like, and
8 you can talk until you are blue in the face. It is
9 like trying to explain blue to a blind man.

10 THE CHAIRMAN: I think we
11 should release you, Mr. Brand, because you do have to
12 get somewhere and we kept you waiting.

13 MR. BRAND: Thank you.

14 THE CHAIRMAN: I call now
15 on Mr. Raymond Wilson. Is Mr. Wilson here?

16 MR. WILSON: I am speaking
17 as a member of the Radicals for Capitalism of Toronto.
18 Every law is based explicitly or implicitly on a system
19 of ethics. Every system of ethics is based explicitly
20 or implicitly on a theory of the nature of man. Man is
21 the animal with a rational faculty. It is his rational
22 faculty, his mind, which is his defining characteristic.
23 It is his mind which is his basic tool of survival.
24 Without the rational ^{thought} of his mind, man could never
25 have discovered how to feed, or to clothe, or to shelter
26 himself. Without the process of thought no man can
27 continue to exist.

28 There are two basic ways in
29 which man can deal with one another, by voluntary consent
30 or by force. Voluntary consent recognizes that since men

1 must think to live, there best and most rational thoughts
2 should govern their dealings with their fellows. Force,
3 on the other hand, interposes a threat between what a
4 man thinks and what he does. Force tells him to do a
5 certain thing regardless of what he thinks about it.
6 It does not matter whether the thing one forces a man
7 to do is in fact the right thing to do, because in
8 principal force is based on the premise that man's
9 rational thought is simply irrelevant. Force thus
10 negates man's basic tool of survival and his very
11 nature. It is the considerations of which the above is
12 a brief summary which leads me to the conclusion that
13 the initiation of force or of fraud, which is a variant
14 of force, no matter what the reason or alleged "good
15 cause", is always morally wrong. The application of
16 this principal to the question of the non-medical use
17 of drugs is that all laws making the possession, use,
18 sale etc. of certain drugs criminal offenses, should be
19 repealed. The possession, use, sale etc. of drugs should
20 not be "legalized". To the degree to which such
21 activities are strictly voluntary, they are properly
22 outside the realm of law. However, it should be
23 probably an offense to sell drugs, particularly hard
24 drugs, to children, since children are almost by
25 definition more easily misled than adults. Such are, in
26 brief, and I emphasize in brief, my thoughts on the
27 morality of drug laws. Their immorality is sufficient
28 cause for their repeal. As to the practical effects of
29 drug laws, the present laws; one, define as criminals
30 a large number of people who are not criminals and impose

1 | absurdly severe penalties on them. Two, encourage those
2 | who are criminals by opening to them an extremely
3 | lucrative field. Three, promote disrespect for justice
4 | and law, and the administrators thereof. And four,
5 | waste the efforts of the administrators and the taxpayer's
6 | money on drug cases to the neglect of their proper
7 | function, the protection of rights.

8 | MR. STEIN: Could you indicate
9 | what the nature of the Organization is, which you, at
10 | the very outset of your comments, indicated? Was this a
11 | representation from that organization?

12 | A MEMBER: It is a representa-
13 | tion from me, in consultation with our President in
14 | Toronto.

15 | MR. STEIN: And could you ---

16 | THE CHAIRMAN: What is the
17 | organization, Radicals for Capitalism?

18 | A MEMBER: It is a philosophi-
19 | cal group which is in basic agreement with the philosophy
20 | of Einrand.

21 | THE CHAIRMAN: You stated
22 | the philosophical principal behind the removal of all
23 | legal responsibilities for --- state responsibility for
24 | the availability of harmful substances.

25 | MR. WILSON: If, as I
26 | outlined in the brief, which was very short, to the
27 | degree to which a transaction involving people is strictly
28 | voluntary, that is, that all the parties to that trans-
29 | action or activity are in it by their own free choice
30 | whether that choice is rational or not, right or wrong,

1 it doesn't matter. To impose force is to make their
2 thought --- make their choice of whether it is right
3 or wrong irrelevant, and that is to negate, as I said,
4 the nature of man.

5 MR. STEIN: Do you apply
6 this principal to all intervention on the part of the
7 state?

8 MR. WILSON: Absolutely.

9 MR. STEIN: And that would
10 include thalidomide or other such drugs? It doesn't
11 matter what the drug is?

12 MR. WILSON: I would say ---
13 I mentioned earlier that fraud is a variant of force,
14 and to market --- to use your example, a drug, which is
15 claimed to have certain effects, and which in fact has
16 other effects which are demonstrably bad, the people
17 responsible for --- in this case the marketing of such
18 a drug, should be held responsible, and this would fall
19 under the category of laws against fraud.

20 DR. LEHMANN: But it is
21 against the law to sell thalidomide today although everyone
22 knows about it and it could well be put on the label for
23 women of child-bearing age and pregnant women, it is
24 dangerous. For others it is not. Would you be in favour
25 of making it freely available with such a label? There
26 would be no fraud then. And how would you feel about
27 heroin, and would you allow anyone to stop somebody
28 from committing suicide?

29 MR. WILSON: I would take the
30 last question first. On the question of suicide, I hold

1 that a man's life is his own. If he considers that he
2 has reasonable grounds to take his own life, it is his
3 to take. Out of loyalty to the principal of the value
4 of life, I for one would take such steps as I could
5 to prevent it if I were confronted with such a situation
6 because I for one am convinced that life is eminently
7 worth living.

8 DR. LEHMANN: But while interfering
9 with what he wants to do it, you might be accused of
10 assault.

11 MR. WILSON: That is possible.
12 If that was the case then I would take the responsibility

13 THE CHAIRMAN: Taking your test
14 of the transaction is voluntary, the law presently
15 prohibits sellers from combining or conspiring to
16 fix the price of a commodity. The combination is a
17 voluntary act and no one is obliged to buy the commodity,
18 and yet we prohibit the price fixing. Would your
19 philosophy of radical capitalism be opposed to that kind
20 of involvement?

21 MR. WILSON: Absolutely.

22 DR. LEHMANN: Would you be
23 in favour of the legalization of thalidomide and heroin,
24 then?

25 MR. WILSON: Yes. Let me add
26 one thing. Myself and other friends with whom I have
27 spoken at great length have considered numerous aspects
28 of what would be--of how a free society would run,
29 and I have come to the conclusion that in such a society,
30 a society such I envisage, there would be many things

1 | which technically people would have a perfect right to
2 | do, and that the Government would have no business
3 | forcing them not to do. However, in such a society, I
4 | quite firmly believe that legislatures would be groups
5 | of men who are held by the public in high esteem, which
6 | is not universally the case in the present society, and
7 | I would be quite sure that if legislatures could pass
8 | any kind of a resolution they want, and to hear it come
9 | down from a group of men who are generally considered
10 | honourable, although they have no right to force people
11 | not to do a certain thing, they consider it senseless
12 | or immoral, or wasteful or self-destructive, I think
13 | that would hold some weight, if the legislatures were
14 | men held in high esteem.

15 | THE CHAIRMAN: Are you
16 | opposed to Government regulations to maintain conditions
17 | of health, regulations of sewage, regulation of the
18 | sanitary conditions, regulation to control communicable
19 | diseases?

20 | MR. WILSON: I would treat
21 | communicable diseases first because that is something
22 | that I'm not certain on. The others, sewers, roads ---

23 | THE CHAIRMAN: Do you
24 | think I should be allowed to leave my garbage out as
25 | long as I want --- I am only compelled by regulation.

26 | MR. WILSON: Certainly not.

27 | THE CHAIRMAN: Well otherwise
28 | I would be free to leave it there to rot, if I wanted?

29 | MR. WILSON: No sir, because
30 | by leaving your garbage out, you are committing an action

1 | which is harmful to others; it is unsightly, smells
2 | bad and it may well cause disease, and there should be
3 | --- and as such, this action is a violation of the rights
4 | of your fellow citizens, and should not be allowed.

5 | THE PUBLIC: Talking about
6 | garbage or marijuana?

7 | MR. WILSON: He is talking
8 | about garbage.

9 | THE PUBLIC: I saw some
10 | similarity there.

11 | THE CHAIRMAN: Anybody else
12 | who has any questions?

13 | THE PUBLIC: I would like
14 | you to clarify a point here. On the one hand, it seems
15 | to me that we are our brother's keeper, that is we are
16 | called upon, which we do very willingly, to provide
17 | services to people and so on. Now where does this
18 | start, where do we say to the person, "you can do whatever
19 | you want when you want," and when do we expect society
20 | to take over and say, now you have gone so far and you
21 | have got problems, and it's okay, we'll look after you
22 | now. And secondly, when you said in your presentation
23 | that quite obviously you couldn't let this be done, or
24 | be offered to children, I would like to know where the
25 | line between childhood and adulthood ends and starts.
26 | Now legally, I know now it is 21 or 16 depending on
27 | what particular laws we are talking about. I know they
28 | are reasonably arbitrary. So I would like your answer
29 | to both of those.

30 | MR. WILSON: As to the age

1 of maturity, that is arbitrary, 16, 18, 21. I really
2 don't know. As to the first, my freedom to swing my arm
3 ends at your nose.

4 THE PUBLIC: But that is
5 not answering the question, the question is, a clarification
6 would like
7 that I/you said people should be free to do to themselves
8 what they want to do. All right, suppose I accept that
9 thesis. But then why am I, as a member of society, then
10 called on to provide funds and so on to look after the
11 person who has done what he feels should be his freedom
12 to do? Why should I be called on to try and look after
13 that person or provide for him?

14 MR. WILSON: You shouldn't.

15 THE PUBLIC: But we are.

16 MR. WILSON: This is not a
17 free society.

18 THE PUBLIC: Well we are
19 called on all the time to provide clinics and so on for
20 people that are in a drug problem, and I agree with this,
21 I think we should try to help them, but I think there is
22 kind of an impasse in my thinking here, when you say, give
23 them their freedom, and on the other hand, since I am a
24 member of society with other people in it, well then you
25 are saying I should look after them when they have done ---

26 THE CHAIRMAN: No, I
27 understand Mr. Wilson to say that he would object to
28 being taxed for the establishment treatment
29 facilities for those who had exercised the freedom
30 of choice in society.

MR. WILSON: I would deny

1 | them treatment at gunpoint. I would deny them treatment
2 | paid by Government out of taxes, which is money collected
3 | essentially, at gunpoint.

4 | DR. LEHMANN: But spontaneous
5 | contribution?

6 | MR. WILSON: Certainly, your
7 | money is yours and we are all free to contribute.

8 | THE CHAIRMAN: Well, what you
9 | deny, as I understand, is any social responsibility for
10 | the treatment, however it is to be organized or paid
11 | for?

12 | MR. WILSON: Right.

13 | DR. LEHMANN: No welfare
14 | state, but welfare, yes.

15 | MR. WILSON: Yes.

16 | THE CHAIRMAN: But no
17 | community responsibility?

18 | MR. WILSON: If anyone wants
19 | to provide it, it is his right.

20 | MR. CAMPBELL: Then like a
21 | charity, that sort of thing?

22 | MR. WILSON: Yes, sir.

23 | THE CHAIRMAN: The gentleman
24 | at the microphone, please?

25 | THE PUBLIC: Something which
26 | sort of got me in that conversation, like thinking
27 | things, the pollution, the Stelco (inaudible),
28 | the big manufacturers in this --- what gets me is that
29 | you are saying you refuse people treatment who, you know,
30 | have done something on their own, like taking marijuana

1 or LSD or speed, and yet you would very probably be
2 quite happy living in a society in which you could
3 enjoy the cars and various plastic commodities we have,
4 and yet these very things, the manufacture of them, is
5 destroying our life style.

6 MR. WILSON: I would not be
7 happy with such a situation.

8 THE PUBLIC: Then you would
9 like to see us go back to the horses and buggies?

10 MR. WILSON: No, I would not.
11 I think that when Stelco dumps noxious substances into
12 the air, it hurts me and you and everybody else, and
13 as an action which is demonstrably harmful to people,
14 it should definitely not be permitted.

15 THE PUBLIC: Could I just ---
16 another thing on the legalization of marijuana --- you
17 said it should be set aside outside the law.

18 MR. WILSON: Right.

19 THE PUBLIC: Wouldn't this
20 mean that it would have to be in fact, legalized before
21 this could happen, because right now, it is illegal.
22 So you would have to legalize it.

23 MR. WILSON: No, if the
24 law is making possession, use, sale, all that sort of
25 thing, illegal, it would be repealed ---

26 THE PUBLIC: This is screwing
27 me up somehow, because if you repeal those laws, does
28 that not make it legal?

29 MR. WILSON: Well, all right
30 then, let me clarify what I said when those activities

1 should not be "legalized". What I mean is they should
2 not set up, for example, a Marijuana Control Board of
3 Ontario. They should let the market supply that and it
4 would.

5 THE PUBLIC: Okay then, we
6 are on the same line, but I think there is a need for
7 some sort of Marijuana Control Board of some sort,
8 because I really don't think that, like you mention
9 the market, well that is fine, but the market itself
10 would probably not have any sort of control.

11 MR. WILSON: Why not?

12 THE PUBLIC: The market
13 right now does not. We can get some stuff right now
14 that can really do harm.

15 MR. WILSON: I know that,
16 but it is underground. Suppose --- I have read that
17 some of the American tobacco companies have gone so far
18 as to file with the patent office for the exclusive rights
19 to Acapulco Gold and so forth. Now if, say, marijuana
20 were legal and you discovered that Acapulco Gold brand
21 grass was good, wouldn't that be sufficient quality
22 control? You would know what you were getting and who
23 you were getting it from.

24 THE PUBLIC: Would this also
25 control prices and things too?

26 MR. WILSON: It certainly
27 would.

28 THE PUBLIC: I don't know,
29 I can't really see that happening, because I think you
30 are going to get an awful lot of bad stuff.

1 MR. WILSON: Is there not a
2 lot of bad stuff, shredded wheat and other stuff going
3 around now?

4 THE PUBLIC: And they are
5 still going to be there after unless there is some sort
6 of control. I think we need some sort of a control.

7 MR. WILSON: If you buy a
8 brand of ^{grass} and it turns out to be bad, are you going
9 to buy it again?

10 THE PUBLIC: No, but how
11 many people will buy it before the time comes when
12 enough people know it is bad, and the word gets around.
13 How many people are going to get screwed up smoking
14 that stuff, how many people are going to get hooked off?
15 Why even bother with that chance; why not have it
16 controlled so you know you are getting something bad?

17 MR. WILSON: If they are
18 hurt by buying bad grass, then that is a case of the
19 people that sold it to them violating their rights.

20 THE PUBLIC: That is fine,
21 but why take that chance?

22 MR. WILSON: And the law
23 should take cognizance of that, because that is the
24 ^{of the government,} function, /to protect rights.

25 THE PUBLIC: I would ask you,
26 sir, this policy of radical capitalism, it is one I have
27 never heard of before; would you deny the existence of
28 unions, of social welfare, the way we have the basic
29 tenants of the welfare system, the welfare state that
30 is just beginning, I think now, and I hope, for my part,

1 continues, would you make --- this is not really on
2 the subject, but would you deny existence of unions?

3 MR. WILSON: Certainly not.
4 Men have every right to combine together to form an
5 organization as long as they as individuals and as a
6 group don't violate anybody else's right.

7 THE PUBLIC: Generally
8 speaking, would you stiffen restrictions against business
9 in the way that it is right now, as far as growth, of
10 inflation, relationship of political problems, different
11 restrictions; would you relax it more to sort of say,
12 free enterprise or more a system of enterprise which
13 is looser with restrictions?

14 MR. WILSON: Absolutely.
15 The basic intellectual foundation upon which such a
16 society would be based, is the idea that the initiation
17 of force is wrong, always, by anybody for any reason.

18 THE CHAIRMAN: But you said
19 that there should have to be some laws --- regulation
20 against pollution. Your system thinks that there should
21 be a regulation about taxation, which would be an
22 interesting solution if you could convince me of its
23 efficacy or perhaps feasibility is the word.

24 MR. WILSON: If Company X
25 put something in the air, and the air is harmful to
26 individual Y, there is a transaction, or there could be
27 said to be a transaction between X and Y. X put the
28 stuff in the air and Y was harmed by it. Now if Y has
29 been harmed ---

30 THE CHAIRMAN: Y can run away

1 from it.

2 MR. WILSON: But he doesn't
3 have to, he has a right to stay where he is.

4 THE CHAIRMAN: He becomes
5 a consenting sufferer if he stays there. Why doesn't
6 he run away?

7 MR. WILSON: He doesn't
8 have to be a consenting sufferer. If he has been harmed
9 then there is a transaction between X and Y in which Y
10 has been harmed, and he should have regress against that

11 THE CHAIRMAN: But providing,
12 why can't he run away?

13 THE PUBLIC: He was an
14 innocent party.

15 MR. CAMPBELL: (inaudible)

16 MR. WILSON: I think it
17 would be the case where a class-action ---

18 MR. CAMPBELL: I don't
19 understand, what is a class-action?

20 MR. WILSON: A suit on
21 behalf of all of the individuals named, unnamed, known, or
22 unknown, who may have been harmed by a specific action
23 by marketing an unsafe Christmas toy, or putting
24 pollution in the air, or something like that.

25 MR. CAMPBELL: You seem to
26 assume a very large amount of free will on the individual.

27 MR. WILSON: I certainly do.

28 MR. CAMPBELL: Surely you
29 aren't going to argue the fact that a child who grows
30 up in the slums with an enormous cultural depravation,

1 enormous social depravation, limitations on
2 education and experience, can be as effectively a
3 human being, operating as a human being, able to excercise
4 choice as an individual who grows up with access to
5 far more education, far more simple experience, diversity
6 of experience?

7 MR. WILSON: Far be it from
8 me to ever make such a claim.

9 MR. CAMPBELL: You see, you
10 have said really, that individuals take actions by
11 choice, then let them look after themselves in terms of
12 the consequences that are unfortunately followed. Now
13 I have seen a lot of people growing up in conditions
14 of extraordinary poverty, I certainly saw this when
15 I lived in the Maritimes, and they have taken actions
16 that would fall into the area of voluntary action. I
17 think largely out of the desperation borne of their
18 environment and limitation on them, and fully appreciating
19 the subtleties of the consequences of their behaviour
20 and, very importantly, having lived in an environment
21 where the time horizon was extremely short, where they
22 lived in families where they derived their income by
23 the week, where the rent was paid by the week, where
24 the father's job would run out by the week, and con-
25 sequently they had no experience of thinking forward
26 four or five or six years. They lived very much in the
27 here and now; they were people who were simply not
28 habituated by their experience to take serious account
29 of the consequences of their actions, because their life
30 was so constrained, so limited to the here and now ---

1 MR. WILSON: How do you save
2 this person?

3 MR. CAMPBELL: Out of that sort
4 of setting, that you do some fool act and the con-
5 sequences are miserable for you, but you chose freely
6 to do the act. Certainly he chose freely in the sense of
7 absence of any external constraint upon his behaviour, he
8 was free in that sense. But don't we as a society, surely
9 have to take some responsibility for him nevertheless?

10 MR. WILSON: Where does that
11 responsibility end? When I go home tonight and have
12 supper, am I to feel guilt every night eating supper as
13 long as there is one hungry person in the world?

14 MR. CAMPBELL: I think there
15 is a great deal of difference between guilt---

16 MR. WILSON: Does the
17 responsibility have no end?

18 MR. CAMPBELL: I think one does
19 not necessarily have deep personal guilt. One may feel
20 a sense of responsibility or compassion without intense
21 guilt.

22 MR. WILSON: Compassion, guilt or
23 responsibility, which is the same thing.

24 MR. CAMPBELL: Good Lord, no.
25 Guilt and responsibility are the same thing?

26 MR. WILSON: If the--the me clarify.
27 When guilt, guilt is a sub-class of responsibility.

28 THE CHAIRMAN: I am wondering
29 if we should call it a day. We might have to take some
30 testimony of some other Commissioners here.

1 I think probably we should
2 conclude. We could go on with great profit. We have
3 been here two days and they have been most constructive
4 for us, but we have various points to get to and I am
5 sure that you are in the same position, so that I would
6 take the liberty of deciding now that we conclude.

7 Thank you, the people of
8 Hamilton, for the reception you have given us here and
9 for the great assistance you have given us.

10 Thank you very much indeed.

11 --- Upon adjourning at 5:00 P.M.

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